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DEVELOPMENT OF A GLOBAL STRATEGY ON INFANT AND YOUNG CHILD FEEDING

Report on a WHO/UNICEF Consultation
For the WHO European Region

Budapest, Hungary
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ABSTRACT

Malnutrition is responsible, directly or indirectly, for half of the 10.5 million deaths each year among children under five years of age. Two-thirds of these deaths occur during the first year of life, and are closely associated with poor breastfeeding and poor complementary feeding practices. Only a minority of infants worldwide are exclusively breastfed during the first months of life, and complementary feeding is often unsafe, inappropriate and inadequate. Malnourished children who survive suffer increased morbidity, impaired development and reduced school performance. Poor feeding practices and their consequences are not only a violation of children's rights but they also threaten social and economic development. In March 2000, a technical consultation on infant and young child feeding was undertaken by WHO in collaboration with UNICEF to discuss issues around feeding policies and practices. Based on the results of this consultation and on accumulated evidence of the importance of the first years for early child growth, a new global strategy was drafted. The aims of the strategy are to improve the feeding of infants and young children and to increase the commitment of governments, civil society and international organizations to protecting, promoting and supporting optimal infant and young child feeding. In May 2001, representatives of 16 Member States in the WHO European Region, as well as nutritional and health experts, gathered in Budapest to discuss this Global Strategy for Infant and Young Child Feeding. The participants contributed to the draft of this new strategy and discussed issues related to its implementation at the national and regional level.

Keywords

NUTRITION POLICY
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WHO Regional Office for Europe, Copenhagen

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1. Introduction

World-wide, reportedly about 30–35% of infants are exclusively breastfed at any time during the first four months of life, and it is estimated that over a million and a half die annually due to inappropriate feeding. More than one-third of under-five children are malnourished whether stunted, wasted, or deficient in iron, vitamin A and iodine. Complementary feeding is often unsafe, inappropriate and inadequate, and the malnutrition that results contributes directly or indirectly to half of the world's annual total of over 10 million young child deaths. Malnourished children who survive, suffer increased morbidity, impaired development, and poor school performance. In addition, the growing scale, variety and frequency of major emergencies, the HIV/AIDS pandemic complexities of modern lifestyles, coupled with continued promulgation of mixed messages and changing fashion with regard to breastfeeding complicate meeting the nutritional needs of infants and young children.

The nutrition of children is of such importance that it is one of the key elements of the child's right to health as defined in the Convention on the Rights of the Child. Children have the right to adequate nutrition, and access to safe and nutritious food; these elements are essential for fulfilling children's right to the highest attainable standard of health. Furthermore, women have the right to decide how to feed their children, and to full information and appropriate conditions that support their decisions. These rights are not yet realized everywhere and the conditions prevailing threaten social and economic development.

Recently, a new Global Strategy for Infant and Young Child Feeding was developed jointly by WHO and UNICEF to address the problem of poor feeding practices and their consequences. In May 2001, representatives of 16 active Member States of the WHO European Region gathered in Hungary to discuss this strategy (the subject of this report). A group of nutritional and health experts were also invited. The objective of the regional consultation was to discuss issues concerning the implementation of the new global strategy to the regional and national context and also to contribute in its final development.

2. Aim of this report

The aim of this report is to document the Consultation held in Budapest, to communicate the discussions covered by individual working groups, and to report the recommendations resulting from the meeting.

3. Opening of the consultation

Professor Laszlo Szonyi, Ministry of Health, Hungary

The Consultation was opened by Professor Laszlo Szonyi. His speech is reproduced below.

Dear Colleagues, Dear Guests,

On behalf of the Hungarian Ministry of Health I would like to open the WHO/UNICEF Consultation for the development of a Global Strategy on Infant and Young Child feeding.

It is a great honour for Hungary to be the host of this very important workshop. In these days, Budapest is the venue of another international meeting, the NATO Summit. The goals of these two consultations are different, but for success, both organisations need international co-operation.

During the past month, I had the opportunity to have a look at J. Diamonds' book entitled 'Guns, germs and steel, the fates of human societies', published in 1997. This book is dealing with a very exciting question: What are the causes of the inequality of the development of different societies on the earth? Some nations are rich and have high living standards. And some nations are suffering from hunger and have low GDP. The answer is rather complicated, but the food plays an exceptional role in the development of the societies.

The main topic of this meeting is to discuss the Global Strategy on Infant and Young Child Feeding and how to decrease the differences. As I am looking around, the members of this meeting are experts of this field. So I am sure, this will be an interesting, fruitful discussion.

I would like to close my words of welcome with Shakespeare:

Timon said in Timon of Athens:

"Tis not enough to help the feeble up,

But to support him after".

Dear Colleagues, I hope, I am sure, you could find the best way to support the governments, the NGOs, health workers in this important field. I wish you successful, open minded brain storming.

4. A new global strategy on infant and young child feeding

4.1. Background to the global strategy

Randa Saadeh, WHO Headquarters, Geneva

A technical consultation on infant and young child feeding undertaken by WHO in collaboration with UNICEF took place in Geneva on March 13–17, 2000. The consultation was attended by experts in strategy and programme development, staff of the two organizations, and representatives of ILO, UNHCR, UNAIDS and the UN ACC Subcommittee on Nutrition. Participants assessed the strengths and weaknesses of current feeding policies and practices, identified barriers to implementation of policies, reviewed crucial interventions in order to identify feasible and effective advances, and contributed to a comprehensive draft strategy that (if adopted) would guide Member States and the international community.

Following the consultation, a new global strategy was drafted as a way forward. The strategy, which takes account of the background documentation and discussions at a technical consultation on infant and young child feeding held in Geneva in March 2000, is based on accumulated evidence of the importance of the first years for early child growth and development; it recognizes the parents' right to decide how to feed their infants and the right of every child to access to nutritious food and adequate feeding. The new global strategy has the following three main objectives:

1. To improve the survival, health, nutritional status, and growth and development of infants and young children through optimal feeding. Ensuring the survival, health and nutrition of women, in their own right and in the context of their role as mothers, is fundamental to attaining this objective.
2. To guide government policy and action – and related support provided by the international community – for protecting, promoting and supporting optimal feeding practices for infants and young children.
3. To enable mothers, families and caregivers in all circumstances to make – and implement – informed choices about optimal feeding practices for infants and young children.

The Fifth-third World Health Assembly in reaffirming the importance attributed by Member States to WHO activities related to infant and young child nutrition and to further discussion of the new global strategy, requested the Director-General to place on the agenda for the 107th session (January 2001) of the Executive Board an item on infant and young child nutrition. The Health Assembly also encouraged discussions on this issue at regional level. As a result, a series of consultations organized by WHO and UNICEF are taking place in all WHO Regions, including Europe. During each consultation, the draft of the Strategy is presented and discussed with a view to developing activities and plans aimed at implementing the strategy in the Regions.

4.2. Aims and operational targets of the Global Strategy

Jose Carlos Martines, WHO Headquarters, Geneva

The aims of the Global Strategy are two-fold. The first aim is to improve the feeding of infants and young children by: 1) protecting, promoting, and supporting optimal feeding practices; 2) empowering all mothers, families and care-givers to make and carry out fully informed decisions about feeding; and 3) ensuring conditions that support exclusive and continued complementary feeding, for every child. The second aim is to increase the commitment of governments, civil society and international organizations to protecting, promoting, and supporting optimal infant and young child feeding.

The main areas of intervention to improve infant and young child feeding should insure that mothers, other caregivers and families should:

- have access to accurate, objective and consistent information about optimal feeding practices;
- have access to skilled support to initiate and sustain optimal feeding practices, and to prevent and overcome difficulties;
- be protected from misinformation and inappropriate commercial influence; and
- be enabled to adequately breastfeed and care for their young infants, including when they have returned to paid employment.

The main intervention areas are already substantially covered by the *Innocenti Declaration*, which sets four operational targets for this purpose. These targets are hereby reaffirmed in the present strategy. The *Innocenti Declaration* targets suggest that all governments should appoint a national breastfeeding coordinator and appropriate authority, and establish a multisectoral national breastfeeding committee, ensure that every facility providing maternity services fully practices all ten of the *Ten Steps to Successful Breastfeeding*, take action to give effect to the principles and aim of all Articles of the *International Code of Marketing of Breast-milk Substitutes*, and enact imaginative legislation protecting the breastfeeding rights of working women and establish means for its enforcement.

This strategy includes five additional operational targets, devised to achieve further progress. Governments should adopt these targets, setting a date and defining measurable indicators:

1. Develop a comprehensive policy on infant and young child feeding.
2. Ensure that society, the health care system and all other sectors protect, promote and support exclusive breastfeeding for six months and that women have access to community support and health services.
3. Ensure timely, adequate, and safe complementary feeding.
4. Develop guidelines on appropriate feeding on infants and young children and on the support required in exceptionally difficult circumstances.
5. Adopt national legislation and other measures for implementing the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety.

A comprehensive policy should indicate how to achieve all of the above targets. This calls for the creation of an effective coordinating body and address the multiple aspects of infant and young child feeding, as well as the establishment of systems for regular monitoring of infant and young child feeding practices in order to assess trends and evaluate interventions. A policy also requires a commitment to the following points:

1. For the protection of breastfeeding, a commitment should be made to: adopt and monitor the application of a policy of maternity entitlements to facilitate breastfeeding by women in paid employment, including those in atypical forms of dependent work; and implement and monitor existing national measures to give effect to the International Code of Marketing of Breast-milk Substitutes and to strengthen them when needed.
2. For the promotion of optimal infant and young child feeding, a commitment should be made to: ensure that all who engage in communicating with the general public are accurately informed and have access to up-to-date information; encourage widespread communication of this information to give greater awareness among health professionals and the general public; ensure that mothers and other family members receive objective and consistent information, free from adverse commercial influences and misinformation.

3. For the support of exclusive and continued breastfeeding, and appropriate complementary feeding practices, various actions should be taken in the health care system and at the community level, and the skills of health workers should be increased through training.

Governments, international organizations and civil society are responsible for achieving the operational targets of the strategy. *Governments* should: develop and adopt a comprehensive national policy; have a fully functioning national coordinating body; develop a detailed action plan built on and integrated with other strategies; identify and allocate financial, organizational and human resources; and engage in dialogue with appropriate civil society organizations. The *international organizations* should place infant and young child feeding high on the international public health agenda. The specific roles of international organizations to protect, promote and support optimal infant feeding, and to support governments in their efforts should include a normative role (development of guidelines, research, global indicators), protection (advocacy and support for the development of policies), promotion, support, guidance and capacity-building, and response to emergency situations. Finally, *civil society* groups with specific responsibility for infant and young child feeding include health professional bodies, commercial enterprises, nongovernmental organizations, and community-based support groups.

5. Rates and trends in infant feeding practices

Short overviews of infant and young child feeding practices in European sub-regions were presented. For the purpose of these presentations, participants worked in the following sub-regional groupings:

- Baltic countries (Estonia, Latvia, Lithuania)
- Central Asian Republics (Kazakhstan, Kyrgyzstan)
- Countries of Central Eastern Europe and Commonwealth of Independent States (Czech Republic, Hungary, Moldova, Slovakia)
- Nordic countries and Southern European countries (France, Israel, Italy, Norway) – the representative of Norway also presented breastfeeding statistics for other Nordic countries (Denmark, Finland, Iceland, Sweden)
- South East European countries (Bosnia and Herzegovina, Bulgaria, Croatia).

Breastfeeding statistics

Breastfeeding rates are described in Table 5.1. The information available suggests that large differences exist among European countries. For example, virtually all newborn babies are breastfed in Israel compared with 51% in France where the median duration of (any) breastfeeding is only two weeks. At three months, the prevalence of exclusive breastfeeding rates varies between 26 and 88%, according to data available. At six months, about 80% of Norwegian babies are breastfed compared with 22% of Lithuanian babies. Variations are even larger for exclusive breastfeeding with 77% of babies in Iceland being exclusively

breastfed at six months compared with 1% in the Republika Srpsua (Bosnia and Herzegovina). Some sub-regions or countries (Central Asian Republics, Nordic countries, France) reported a trend towards increasing breastfeeding rates during the past decades.

Some regions discussed selected factors related to breastfeeding rates. In France, it appears that higher rates are observed in women of higher socio-economic status and in those of African origin. In Israel, it was reported that Arab women breastfeed their children for longer compared with Jewish women, and that breastfeeding rates are higher in women who had a regular delivery, in infants “rooming-in” all day at the hospital, and in infants who were not given infant formula at the hospital. In that country, 19% of newborns receive infant formula at the hospital. It is also reported that while at the hospital, 26% of newborns receive water and 30% receive a pacifier. In Italy, large regional differences in breastfeeding rates were reported.

WHO/UNICEF consultation for the WHO European region for the development of a global strategy
on infant and young child feeding: Report on a WHO/UNICEF consultation,
Budapest, Hungary, 28 May–1 June 2001

Table 5.1. Prevalence of breastfeeding by sub-region and country

Category	Baltic countries			Central Asian Rep.			CCEE & NIS				Nordic countries				Southern Europe			SE Europe		
	Est %	Lat %	Lit %	All %	Kaz %	Kyr %	Cze %	Hun %	Slov %	Mol %	Nor %	Den %	Icel %	Swe %	Fra %	It %	Isr %	B&H %	Bul %	Croa %
Ever breastfed																73				
At birth							88	66	92	84	99	99		98	51		100			
At birth (EBF ^a)							57										9 (1day)		99 (3-4d)	95 (1day)
0-3 months				95-98																
0-3 months (EBF)					47	13														
At 3 or 4 months							47 (4m)	53 (4m)	72 (3m)		71 (3m)						49 (3m)			
At 3 or 4 months (EBF)	60 (3m)	33 (3m)	45 (3m)		87 (3m)	88 (3m)	29 (4m)						69 (3m)		25	26 (3m)		FBIH:34 (3m)	45 (3m)	37 (3+m)
																		FBIH:8 RS:1 (4m)		
At 6 months	36	28	22		74	79	53				80						50			
At 6 months (EBF)							23		28				52	77	73	17 (5-6mo)	22	FBIH:6 RS:1	24	24
At 1 year			7				17					10		43			25	FBIH:41 RS:23		1.6 (predom ^b)
Mean/median duration				14-17 mhs (mean)											2 wks (med)		21-25 wks (mean)		1-12 mths	3.5 mths (mean)

^a EBS = exclusive breastfeeding ^b Predominant breastfeeding

SE Europe=South East Europe, Est=Estonia, Lat=Latvia, Lit=Lithuania, Kaz=Kazakhstan, Kyr=Kyrgyzstan, Cze=Czech Republic, Hun=Hungary, Slov=Slovakia, Mol=Moldova, Nor=Norway, Den=Denmark (information supplied from 1987/88), Ice=Iceland, Swe=Sweden, Fra=France, It=Italy, Isr=Isr, B&H=Bosnia & Herzegovina (FBH: Federation of Bosnia/Herzegovina; RS: Republika Srpsua), Bul=Bulgaria, Cro=Croatia

Complementary feeding statistics and problems related to infant and young child feeding

Problems related to infant and young child feeding were discussed by some sub-groups. One main issue found in all regions is the early introduction of complementary foods. In Israel for example, it appears that 35% of all mothers who began breastfeeding start giving their babies foods and drinks before the end of the first month.

In the Baltic countries, while most newborn babies are breastfed in maternity houses, it appears that approximately 50% of them receive breast milk substitutes or glucose water. Early introduction of complementary foods – including cow milk – appears to be another problem in these countries. On average, complementary foods are introduced at 3.8 months of age. In Estonia, 59% of infants start eating foods at around four months of age (20% before four months), while this is the case in 70% of infants in Latvia and 60% in Lithuania. In Estonia and Lithuania, cow milk is consumed by approximately 17% of four-month old babies, 48% of six-month old babies (54% in Estonia, 42% in Lithuania), 64% of nine-month old babies and 77% of 12-month old babies. A study performed in Estonia suggests that the main reasons for introducing new foods in an infant's diet is the belief that the age is appropriate (58%) or that "there is not enough milk" (25%), or a recommendation by medical staff (11%).

In the Central Asian Republics, several types of problems were perceived as important. These included: the wide and early use of undiluted cow milk and tea, the early or late introduction of complementary foods, the low energy density and low variety of complementary foods, the late introduction of meat (after eight months), and the low frequency and amounts of meat, fish, eggs, and beans. It was suggested that these problems arise as a result of the lack of nutritional training of medical staff and the use of old-fashioned recommendations.

In countries of the Central and Eastern Europe, the main feeding problems were perceived to be non-exclusive breastfeeding, the use of infant formula, and the early introduction of complementary foods. In the Czech Republic, approximately 40% of babies start eating complementary foods before the fourth month. In Hungary, it is about 34% of all four-month old babies that have been initiated to complementary foods. In Moldova, the main issue of concern was the early introduction of undiluted cow milk (from three months of age).

In South Eastern European countries, the lack of adequate training and the resistance to change among health professionals were mentioned as important problems related to inadequate infant and young child feeding in the region. In Croatia, complementary feeding is introduced at about 4½ months on average. In Bosnia and Herzegovina, it appears that about 54% of the babies start consuming complementary foods before six months. In Bulgaria, data from IBFAN suggest that some babies are initiated to complementary feeding as early as the seventh day (e.g., tea or Nestle). Current recommendations in Bulgaria still suggest that fruit juices be introduced during the second month, fruits and vegetables at the end of the fourth month, milk/fruit puree and egg yolk during the fifth month, and meat and vegetable puree during the fifth month.

6. Surveillance: its importance as a planning and advocacy tool

6.1. Surveillance for planning, monitoring, and advocacy

Francesco Branca, National Institute of Nutrition, Rome, Italy

(extract unavailable)

6.2. Indicators for assessing infant and young child feeding practices in Lithuania

Jovile Vingraite, Vilnius, Lithuania

The State's health programme entitled "Nutrition improvement for infants and children under three years of age" was launched in Lithuania in 1994. The coordination of the surveys, carried out within the framework of this programme, is conducted by the National Nutrition Centre. The surveys include interviews of mothers who have a child between birth and three years of age. Women coming from all parts of Lithuania are included in the surveys. Interviews are conducted by the staff of the National Nutrition Centre or by specially trained workers from the regional public health centres.

Surveys concentrate mainly on infant feeding practices, that is, on breastfeeding, consumption of breast-milk substitutes (formula, cow's milk), and on complementary feeding. Mothers are asked to provide information on the age at which their child started or stopped particular foods, and to describe current feeding patterns. There is also a follow-up study of infants from birth until 12 months of age.

Indicators of breastfeeding practices included in the survey consist of the time of initiation of breastfeeding, the duration of exclusive and predominantly breastfeeding, and the total duration of breastfeeding (until fully stopped). Other feeding practices related to milk consumption are assessed using indicators such as the infant's age at the introduction and discontinuation of infant formula, the type of formula used (regular, iron fortified, for special needs, home-made), and the age at which the child started cow's milk (in general and as a sole source of milk). Mothers are also asked about when other complementary foods were started, and about the usual amounts of meat, fish, fresh cow's milk, curd, and tea (and type of tea) are consumed. Feeding between 12 and 24 months is assessed by indicators such as: continued breastfeeding, daily amount of fresh cow's milk consumed, use of sugar and daily amount consumed, consumption of family foods and specially prepared foods, use of bottle (for milk and for other drinks), and dental care.

6.3. Validation, calibration and reliability - confused thoughts...

Dorit Nitzan Kaluski, Department of Nutrition, Ministry of Health, Jerusalem, Israel

The requirements for measuring dietary habits differ for different epidemiological study designs, the food of nutrient of interest, and the variability of the measure in the study population. Accurate assessment of dietary intake, when based on self-reporting from free-living populations poses significant scientific challenges. All standard dietary assessment methods, including food diaries, dietary recalls, food-frequency questionnaires, are subject to considerable error and bias.

Methods of measurement of intake should be evaluated according to their validity (1) and reproducibility. The validity of a method has been defined as the determination of how well the method measures that which it should measure. As it is impossible to know accurately the real intake of an individual over a long period of time, the absolute validity (the comparison of the method with the truth, “gold standard”) cannot be measured. Instead, the relative validity (2) or indirect validity (3) is usually evaluated by comparison with another method, used as a method of reference. The latter, considered to be the more accurate method, has not, however, been validated in relation to the truth. In other words, during the development or selection of the questionnaire method, correlations between measurements and true intake levels should be monitored. Validation requires at least two reference measurements. Calibration does not estimate the sources of measurement errors separately and require only a single reference measurement. In calibration studies the systematic measurement error and the variance of the calibrated measurements are estimated, but not the separate variances of the random measurement error and the true intake. Thus, a calibration study is only a part of what would be required for a proper validation study (even assuming a measure of the “true” intake).

It is implicit in these validation studies that the comparison is between two measures derived from methods that seek to describe dietary habits, and that one of these measures is assumed to be more accurate (the reference measure derived from the reference method). It may not always be clear which method to use as the reference method, especially when the research aims to find out about long-term habitual intakes. Up to now, a weighted record of several days duration has most often been taken as the reference method.

The reproducibility (“test-retest reliability”) measures the extent to which a method obtains the same results when applied to the same subjects and under the same conditions on two separate occasions (3). It should be remembered that the results of reproducibility considered separately from those of validity are difficult to interpret – whilst knowing whether what is being measured remains constant, it is not known whether intake is being measured equally badly on both occasions (4).

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6.4. Surveillance: methodological issues

Michel Chauliac, Direction Générale de la Santé, Paris, France

The use of common indicators that would allow for the surveillance of infant and young child feeding in Europe is necessary. However, as cultural and social factors, history, health care systems, and breastfeeding and complementary feeding practices vary among countries, the types of indicators and the methods of data collection to be used might need to be adjusted from one country to the other. For example, some indicators might be useful in one region but not in another (for instance indicators related to the early introduction of cow milk may not apply to all regions).

In any case, when deciding on a set of common indicators, it is important to be very clear about the following:

- Why we want to get the information:
We want the information to evaluate a situation and compare indicators within space and time. We want to help policy makers, particularly public health policy makers, to take decisions and to adapt their decisions on infant and young child feeding within the framework of a global nutrition and health policy.
- Who takes the decisions:
Policy makers take the decisions while technicians give them the arguments. So technicians have to tailor their arguments to the way decisions are taken. The mandate of a politician is short – thus the results of his/her decisions have to give results quickly. On an economical point of view, it is very often more important for a politician to increase the GDP of his/her country than to develop strategies (and invest money) that will reduce health care costs in the future. Finally, technicians have to present data in a concise and clear way as policy makers do not usually have the required technical background. It is also important to remember that many topics are ‘competing’ to have the attention of policy makers and be considered as priorities. As a result, the arguments submitted have to be very strong.

Of course, the selected indicators have to be reliable (and the definitions of how data are collected is of primary importance), sensitive, and specific.

There are two main ways of collecting data on infant and young child feeding, that is, cross-sectional surveys and continuous monitoring.

1. Cross-sectional surveys

A cross-sectional survey gives a description (“picture”) of a situation at one point in time. The methods used can be well planned and controlled by a competent team in terms of sampling (ideally a random sample should be taken in order to be able to generalize the results) and data collection. All team members can be well and specifically trained, and a supervisor can daily control the data collected, correct some errors, and re-train staff if required.

Costs are variable and will depend on the size of the sample, the possibility to use telephone interviews, travel expenses, the cost of personnel, etc.

Memory problems and recall bias can arise for some types of data. A validation system might thus be needed. The cross-sectional design does not allow for a comprehensive

investigation of the past experiences of each child and so does not allow for an analysis of the association of current health and nutritional status with infant and child feeding history.

Cross-sectional surveys have to be repeated regularly in order to allow for time trend analyses. This means that the same methodology has to be repeated and that new human resources have to be found to perform the study. Decisions cannot be adopted as precisely between the surveys.

In this approach, fieldworkers are not involved in the assessment of the situation. Therefore, they may feel excluded from the decision process and lack motivation to act upon the application of the recommendations made.

2. Continuous monitoring

This technique gives a continuous description (“movie”) of a situation. Children seen within the health system are regularly checked and mothers interviewed to provide information in a standardized way. This method allows for a continuous analysis of trends and permits an adaptation of the decisions year after year, within groups or geographical areas. It helps maintain motivation among the staff members who are collecting the data. However, this technique requires that good communication links are established from the bottom to the top level of the health care system so that data reach decision makers in time, and from the top to the bottom level so that personnel members are informed quickly of the decisions that were taken.

Such a system permits the investigation of associations between past exposures (as it gives data from the past at the individual level) and the current health and nutritional status of children.

Continuous monitoring might not lead to high costs into the regular budget of the health care system. It must be as “light” as possible, avoiding many steps between the bottom level and the top.

It necessitates a high level of attendance (consultations) of families to the health services, as well as a standardized way of identifying and contacting families who are not using the health care services. It might be easier within a strong public health sector, as it still exists in many countries of the Former Soviet Union.

Once started, with all the data collection tools being in place, it is difficult to change the monitoring system in place as this would mean that all the different persons involved in collecting the information would need to be informed and trained with regards to the required changes.

A sample of health centres might be sufficient to allow for a good supervision of the situation. However, due to demographic changes over time, the results provided by the continuous monitoring system might change.

This kind of system can be at times completed by a cross-sectional survey used to test other hypotheses.

7. Training courses related to infant and young child feeding

7.1. Overview of promoting perinatal care and integrated management of childhood illnesses strategies in the European Region

Viviana Mangiaterra, WHO Regional Office for Europe

The WHO Regional Office for Europe Department of Child and Adolescent Health and Development (CHD) is involved in various areas of interventions including include “Promoting Effective Perinatal Care” (PEPC), the “Integrated Management of Childhood Illnesses” (IMCI) and promoting child protection.

PEPC aims to reduce morbidity and mortality in mothers and newborns and promotes the use of appropriate technology for birth, neonatal care and breastfeeding, through a holistic approach, including evidence-based care and cost-effective interventions, in line with the Making Pregnancy Safer Global Initiative. Perinatal strategies have a lot to offer for improving infant nutrition: the opportunity to improve family diet, in particular diet for pregnant and lactating women, iron and iodine supplementation if needed, the improvement of obstetric and new-born care practices, and support to BFHI and promotion of breastfeeding. In the WHO European region, three countries are currently in the expansion phase of implementation of PEPC (Belarus, Kyrgyzstan, Moldova) while seven are in the early implementation phase (Azerbaijan, Georgia, Kazakhstan, Russia, Tajikistan, Turkmenistan, and Uzbekistan).

The IMCI was developed by the CHD in collaboration with eleven other WHO programmes and UNICEF. This strategy encompasses interventions at home and in the health system. It aims to reduce childhood death, illness and disability and to contribute to improved growth and development. The strategy addresses the five major life-threatening conditions of childhood: acute respiratory infections (ARI), diarrhoea, measles, malaria, malnutrition and other associated conditions. The IMCI offers specific adapted feeding recommendations for children under five years of age, the opportunity to improve practical child feeding practices, counselling on breastfeeding and complementary feeding, the treatment of malnourished children, vitamin A and iron supplementation if needed, and the treatment of helminths. The CHD programme is promoting the introduction of IMCI in the countries of the Region with high mortality and morbidity rates under five years of age, particularly in Central Asian Republics and Caucasus countries. Through the implementation of the *First Action Plan for Food and Nutrition Policy* developed by the WHO Regional Office for Europe, the PEPC and IMCI strategies are very instrumentals in different areas: the detection of feeding problems, recommendations based on EURO Guidelines on complementary feeding and BF promotion, the adaptation of local Food box as a part of algorithms of IMCI. Current recommendations on feeding and nutrition of infants and young children for the European Region have recently been published (1).

1. MICHAELSEN, K.F. ET AL. *Feeding and nutrition of infants and young children*. Copenhagen, WHO Regional Office for Europe, 2000.

7.2. Nutrition of pregnant and lactating women – training experiences from Central Asian Republics

Gauchar Abouva, Almaty, Kazakhstan

A training course entitled “Healthy Nutrition of Pregnant and Lactating Women and their Families” was used recently in the Central Asian Republic. This course was based on the WHO/EURO Training Module designed for countries of the former Soviet Union. It was given in Russian to gynaecologists-obstetricians, paediatricians, general practitioners, hygienists from sanitary-epidemiological centres, non-governmental organizations, nutritionists, nurses, midwives, and policy makers responsible for women and child health.

The aims of this course were to provide health professionals with modern, recent, evidence-based, practical information on healthy nutrition for pregnant and lactating women, to develop skills in providing pregnant and lactating women with sound nutritional advice based on current scientific knowledge, and to develop professional and managerial capabilities. During this course, the participants were trained in the basic principles of a healthy diet, and on the evaluation of nutritional status and dietary intake. They also became familiar with public health nutrition methods.

The training course included the following five main sessions:

- a) nutritional status and food intake of non-pregnant, pregnant and lactating women;
- b) recommendations on nutrient intake for pregnant and lactating women, as well as women of childbearing age (who might become pregnant);
- c) nutrition-related problems in pregnancy;
- d) food choices, food safety, and the impact of smoking; and
- e) nutritionally compromised mothers and the need for specialized referral.

The learning objectives of the course were to:

- a) understand the relationship between nutritional status and food intake;
- b) describe current dietary guidelines for a healthy adult population;
- c) list the nutritional requirements before pregnancy and during pregnancy and lactation;
- d) describe the factors affecting food choice in women;
- e) evaluate the nutritional quality of women’s diets according to international guidelines;
- f) list nutrition-related challenges that may be encountered during pregnancy;
- g) identify vulnerable groups in the population and define the nutritional advice that they need; and
- h) develop an action plan for the development of a nutrition and health policy, including nutritional education for women in the region.

Each course took place during three consecutive days, and for eight hours on each of these days. The format of the course included formal lectures, group work, and homework consisting of readings and data collection prior to the beginning of the course. Group work covered the following areas: quick and easy methods of assessing the nutritional quality of a woman’s diet; design of simple leaflets providing advice on healthy eating and lifestyle for mothers; four case studies; and draft of a regional food and nutrition action plan for the development of a nutrition and health policy concentrating on women.

7.3. Training courses in complementary feeding

Zuzana Brazdova, Department of Preventive Medicine, School of Medicine, Brno, Czech Republic

The training course module on “Feeding and Nutrition of Infants and Young Children” was based on the publication produced by the Regional Office for Europe, (Michaelsen, L. et al., ISBN 92 890 1354 0). Its aim is to provide health professionals with the theoretical and practical scientific knowledge and skills in the areas of infant and young children feeding and nutrition, as well as in breastfeeding promotion.

The learning objectives of the module include:

- promoting the understanding of: 1) the health problems of infants and children; 2) the nutritional status of children; 3) the recommended dietary intakes (energy, macro- and micronutrients); 4) nutritional deficiencies; 5) nutrition-related health problems and diseases in children (prevalence – international and regional data, etiology, risk factors, prevention);
- developing and improving the quality of the advice given to breastfeeding mothers, including recommendations on breastfeeding practices;
- developing the standard of counselling of mothers about complementary feeding;
- developing the skills for growth assessment and growth evaluation with a special emphasis on stunting and wasting, as well as obesity;
- developing the skills for dietary assessment (24-hour recall, dietary history, and food frequency questionnaire);
- developing and improving the knowledge of food safety (Hazard Analysis of Critical Control Points (HACCP)), including counselling on food safety issues;
- providing an overview of international healthy eating guidelines for children aged between 5 and 15 years;
- discussing the standards of infant and children nutrition in emergency (need for referral, criteria for the definition of nutritionally compromised family, community nutrition problems of children from families of refugees and internally displaced people (IDP’s), need for humanitarian assistance); and
- giving an overview of existing international resolutions (ICMBMS, WHA) and activities (IMCI, International Baby Food Action Network (IBFAN), BFHI, PEPC, etc.) in the area of infant and child feeding.

The course is based primarily on lectures, group work, formal presentations, case studies, play game, motivational tests, individual reading time, and multiple choice test exams. The material used in the course includes:

- the WHO publication by Michaelsen, K. et al. *Feeding and nutrition of infants and young children*. Copenhagen, WHO Regional Office for Europe, 2000;
- various printed handouts (food composition tables, growth charts, nutritional guidelines);
- some documents provided before the beginning of the course (dietary questionnaires, 24-hour recall forms, food-frequency questionnaires);
- case studies (for group and individual work) with solution sheets;
- tests based on case studies and multiple choice questions, with solution sheets;
- questionnaires for the evaluation of the course; and
- course certificate

The training course program covers various topics, including:

- health and nutritional status and feeding practices;
- recommendations on nutrient intakes;
- nutrition-related health problems (Dental health, Allergies, Anorexia, Pica syndrome);
- control of iron deficiency;
- dietary guidelines for children 5 to 15 years of age;
- factors influencing children's food choice (neophobia, neophilia, physiological and psychosocial factors of adoption taste and food preferences and aversions, culturally appropriate/accepted foods);
- breastfeeding and alternatives to breastfeeding;
- complementary feeding;
- growth assessment;
- dietary assessment;
- food safety; and
- nutrition in emergency.

Four pilot training courses have already taken place in the North Caucasus and Uzbekistan between January and May 2001.

8. Developing strategies on infant and young child feeding for sustainability: experiences and lessons learned

8.1. Developing strategies on IYCF for sustainability

Genevieve Becker, BEST (Breastfeeding Education Support and Training) Services, Galway, Ireland

A strategy needs to be appropriate for the situation, agreed by those involved and applied in a sustainable manner. A key element of a sustainable strategy is to have a plan:

1. Where are you starting from – what is the present situation? As well as problems, what is working well that can be reinforced?
2. What is your goal or target? An achievable target is one that is agreed by the major stakeholders. If some of the stakeholders do not recognize that there is a problem that needs changing, you may need a preliminary stage when the “problem” is explained to the stakeholders and any questions addressed. The target needs to be realistic to the situation. If the target is too easy, some people may sit back and do nothing. If it is set too high, people may decide they can never achieve it and do nothing. There may need to be overall aspirational aims as well as more local operational targets.
3. How will you reach your goal? Breastfeeding and appropriate complementary feeding are natural, healthy activities. Your projects may focus on facilitating these activities. However, also consider activities that reduce the barriers – artificial feeding and inappropriate complementary foods. Exclusive breastfeeding rates will not rise unless artificial feeding rates reduce. Similarly, appropriate timing of the introduction of complementary foods will not take place unless early introduction stops. Look at the situation from both aspects when looking for solutions. There are many types of interventions and actions that can be used: Education; Communication; Environmental change to either facilitate or to make difficult the behaviour; Regulations; Organizational; Economic and other incentives; Social support; Advocacy. It is useful to review activities that were used in other settings – what worked and what didn’t work. Knowing why an activity did not work might be as useful as knowing why another activity did work.
4. How will each strategy/activity towards your goal be measured or evaluated? The evaluation of a project does not need to be left to the end. Process evaluation should be carried out in such a manner that the results are available quickly to make any changes needed.
5. How will you sustain it? Care needs to be taken that activities are not undertaken just to be seen to be taking action or as once-off promotional activities. Often, sustainability is achieved by integrating the change into existing processes and policies. For example,
 - that baby friendly practices are accepted as part of ongoing audits and accreditation of hospitals;
 - that health worker pre-service training is adequate to assist breastfeeding and qualifying exams assess their breastfeeding knowledge and skills;

- that each new piece of government policy and legislation is automatically assessed for its impact on children's rights and needs. The solution to sustainability may be how we can integrate infant and young child feeding and overall needs into the wider situation through multisectoral collaboration.
6. What resources are needed? As well as time and money, the major resource needed is people. Projects can look wonderful on paper, however paper does not implement them – people do. People with ideas, people with action, people to help, people to motivate, and people working together are all needed. Democratic governments are elected by people and taxes are paid by people. Healthy children are the future of a nation. All the children together are the future of the world. Advocacy and other groups may need to encourage all the people in a country or other area to see they have a role and responsibility in supporting the wellbeing of children.

8.2. Towards national, regional and local strategies for breastfeeding – the United Kingdom experience

Andrew Radford, United Kingdom Baby Friendly Hospital Initiative, London, United Kingdom

The United Kingdom comprises four countries – England, Northern Ireland, Scotland and Wales – each with its own responsibility for health policy. All four countries have relatively low breastfeeding rates and have resisted pressure to adopt policies on breastfeeding.

The United Kingdom Baby Friendly Initiative, which is part of the United Kingdom Committee for UNICEF – an NGO, produced a document entitled “Towards National, Regional and Local Strategies for Breastfeeding” in order to support advocacy for strategies and policies at all levels of society. The document is addressed to national and local government, the health care system, local communities (including schools and businesses), trade unions, voluntary organizations and individuals and suggests action to:

- protect a mother's right to breastfeed;
- implement best practice in the health care system;
- provide accurate and impartial information and support; and
- set targets; audit and support progress towards them.

The document has been used as part of the development of breastfeeding strategies in Northern Ireland and Wales. In Scotland, the 15 health authorities were asked in the mid-1990s to develop individual strategies, and the UNICEF document has been used by some as the strategies have recently been revised and updated. Evidence for success is not yet fully available, but Scotland, which has a longer experience of strategies than the other parts of the UK, is showing faster increases in its breastfeeding rates and has a greater proportion of its births in Baby Friendly hospitals.

Nevertheless, it is felt that the adoption of coherent national policies by each of the four countries would be more effective than the current rather piecemeal approach.

8.3. International Lactation Consultant Association (ILCA)

Johanna Thomann, International Board Certified Lactation Consultant, Bern, Switzerland

The International Lactation Consultant Association (ILCA) is a global non-governmental association for health professionals who specialize in breastfeeding. It includes professional lactation consultants, midwives, paediatricians, teachers, speech therapists, and other health professionals. The ILCA was incorporated in 1985 and includes 5 000 members in nearly 50 countries. It has official relations with WHO. European members of the ILCA can also join the Verband Europäischer Laktationsberaterinnen (VELB) – an organization affiliate to the ILCA providing the same services as the ILCA but on a European basis.

The ILCA offers professional, practical, clinical and evidence-based technical support to its members, including evidence-based guidelines, position papers, a scientific journal (Journal of Human Lactation), conferences, and education models for continuing education.

The members of the ILCA are International Board Certified Lactation Consultants (IBCLCs). They are allied health care providers who, by meeting eligibility requirements and certifying by passing an independent examination, possess the necessary skills, knowledge, and attitudes to facilitate breastfeeding. With a focus on preventive health care, they encourage self-care and parental decision-making prenatally and postnatally. IBCLCs use a problem solving approach to provide appropriate information, recommendations, and referrals, in a variety of settings. They can provide practical support not only to breastfeeding mothers, but also to health care workers and policy makers.

The international Board of Lactation Consultant Examiners (IBLCE) is a non-profit corporation established in 1985 to develop and administer certification for lactation consultants. It has been fully accredited by the prestigious United States National Commission for Certifying Agencies (NCCA), the body which sets stringent standards for certifying organizations. The IBLCE:

- sets standards that protect mothers and babies;
- independently evaluates professional competency;
- enables identification of recognized skills;
- motivates health professionals to broaden their breastfeeding expertise;
- recognizes that specialist skills in lactation are needed by multiple professions;
- raises standards of care in lactation management;
- initiated the development of a skilled profession; and
- protects, promotes, and supports breastfeeding worldwide.

The ILCA and IBLCE function independently of each others, and the ILCA acknowledges the IBLCE examination as the professional credential for lactation consultants.

9. Integration of infant and young child feeding into education, national policies and community services

9.1. Integration of breastfeeding education and BFHI into pre-service and in-service education: Experiences from the United Kingdom

Fiona Dykes, Department of Midwifery Studies, Faculty of Health, University of Central Lancashire, United Kingdom

This summary describes a university short course (module) in breastfeeding (developed by Fiona Dykes). The module is taught over 12 weeks and includes three taught hours per week plus independent study hours. The module forms a compulsory part of the four year programme of education leading to a Bachelor of Arts (Honours) Degree in Midwifery. The module may also be taken as an option on courses for qualified Health Professionals e.g. Master of Arts Degree in Midwifery and Master of Science Degree in Food and Health, both offered in the Faculty of Health, at the University of Central Lancashire.

The module incorporates the content of the WHO/UNICEF (1997) Breastfeeding management modular course including the clinical practices. Topics taught on the University breastfeeding module include:

- Socio-cultural influences upon women and their breastfeeding choices and practices
- Related history and anthropology
- International Code of Marketing of Breast-milk substitutes (WHO 1981)
- WHO/UNICEF Baby Friendly Hospital Initiative (BFHI)
- Physiology of Lactation
- Antenatal information giving
- Supporting women in establishing and maintaining breastfeeding
- Teaching hand and pump expression
- Dynamic properties of human milk
- Psychosocial aspects of breastfeeding
- Supporting women with breastfeeding challenges
- Support for breastfeeding women in the community
- Lactational Amenorrhoea Method of family planning
- Family Dynamics and Psychosexual issues

Midwives play a key role in the United Kingdom in supporting breastfeeding women during the first four weeks following the birth. The advantages of in depth teaching in breastfeeding to undergraduate student midwives (pre-service) is that they enter the maternity care system with an excellent knowledge in this area. This greatly assists maternity care providers in working towards and maintaining the BFHI award and enables women to receive appropriate evidence-based information from knowledgeable health care workers.

Related publications

DINWOODIE, K. ET AL. The baby friendly breastfeeding management course. *British journal of midwifery* **8**: 362–366 (2000).

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9.2. Using the UCLan BeSST tool to evaluate breastfeeding support skills

Victoria Hall Moran, Department of Midwifery Studies, University of Central Lancashire, Preston, United Kingdom

The role of the health care worker in supporting breastfeeding is well documented. However, there is currently very little research evaluating the specific clinical skills required by health workers to assist women to breastfeed. Research has been carried out at the University of Central Lancashire United Kingdom (UCLan) to develop and validate a quantitative measure of breastfeeding support skills, the Breastfeeding Support Skills Tool (BeSST). The tool has been used evaluate breastfeeding support skills of midwives following the WHO/UNICEF 20-hour Breastfeeding Management course (5). The 20-hour course has previously been shown to improve the knowledge and attitudes of health workers towards supporting breastfeeding women (1,4). The current study tests the hypothesis that midwives who have completed the 20-hour course would score significantly higher the BeSST than a control group of midwives who have not undertaken the course.

After being subjected to a rigorous validation process (2), the BeSST was used in a between-subjects design comparing midwives who had attended the course in the previous two weeks (N=15) with others who had not attended the course (N=13). The BeSST consists of a questionnaire and accompanying video clips, chosen to illustrate the following key aspects of breastfeeding: positioning and attachment; recognizing effective suckling; recognizing breast abnormalities. Breastfeeding support skills were found to be significantly improved ($t(23.39) = 2.94, p < 0.01$) in participants who had completed the course (mean score = 29.9) compared with those who had not (mean score = 19.8) (3).

Our research has clearly indicated that breastfeeding support skills, as illustrated by the BeSST, are significantly improved two weeks following the 20-hour course. The tool is currently being used in other projects, such as WHO/UNICEF course evaluations in Vietnam and Ireland and in a Department of Health United Kingdom project. Further developments of the tool are currently underway which will involve the digital re-recording of the video footage to include multi-cultural images to enable the tool to have a wider application.

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1. DINWOODIE, K. ET AL. The baby friendly breastfeeding management course. *British journal of midwifery* **8**: 362–366 (2000).
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9.3. Using Baby Friendly principles to introduce best practice in support of breastfeeding into community health care, paediatric units and educational institutions.

Andrew Radford, United Kingdom Baby Friendly Hospital Initiative, London, United Kingdom

Information about three areas of activity by the UNICEF United Kingdom Baby Friendly Initiative was presented:

1. the development, launch and implementation of the Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care Settings;
2. the proposed development of best practice standards for breastfeeding protection and support in paediatric units; and
3. the development and projected implementation of best practice standards and an assessment and accreditation procedure aimed at ensuring a high standard of education on breastfeeding for student health professionals.

The principles of the Baby Friendly Hospital Initiative can be used as a tool to improve care and support for breastfeeding mothers and babies throughout the health care system. It is recognized that breastfeeding support in the community and paediatric services could also be improved and that the current training for student midwives and health visitors (the major carers for breastfeeding mothers in the United Kingdom health service) is largely inadequate. A similar approach is adopted for each of the three new areas:

- a. identify the problem;
- b. appoint a working group of experts to propose a solution;
- c. consultation with key players; and
- d. launch: as guidance for best practice, and/or providing Baby Friendly assessment and accreditation.

In the United Kingdom, a two-year consultation took place to identify best practice standards for community health care provision (health visiting, general practice, community health centres, etc.). This resulted in the Seven Point Plan (below), which follows the same principles as the Ten Steps to Successful Breastfeeding. It is developed specifically for the United Kingdom health care system, although has been adapted successfully for use in other countries. A guiding principle was to ensure consistency of advice for mothers and continuity of care when care is passed from the maternity to community services. The third full Baby Friendly award for community health care services was achieved during this seminar. Four other community facilities have a Certificate of Commitment.

Similarly, draft standards have been developed for training institutions (below) and a similar process is underway for paediatric units. The standards for paediatric units are being developed from a Good Practice Guidance document developed by the Royal College of Nursing, the Royal College of Paediatrics and Child Health and the UNICEF United Kingdom Baby Friendly Initiative in 1998. Fuller information can be found on the web site – www.babyfriendly.org.uk.

It is recognized that the three expanded programmes should acknowledge the importance of good complementary feeding practices. The existence of similar developments in other countries (e.g. paediatric standards in Australia and Oman; neonatal standards in Norway) is also acknowledged.

Seven Point Plan for the protection, promotion and support of breastfeeding in community health care settings

All providers of community health care should:

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Support mothers to initiate and maintain breastfeeding.
5. Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote cooperation between healthcare staff, breastfeeding support groups and the local community.

Draft standards for training institutions

In order to ensure the highest level of education in support of breastfeeding, all institutions providing education to student midwives or health visitors should:

1. Make a written commitment to adhere to these standards.
2. Ensure all students are equipped with the skills fully to support breastfeeding mothers.
3. Provide teaching without involvement, sponsorship or promotional materials from the bottle feeding industry.

9.4. Integrating infant and young child feeding into national policies

Genevieve Becker, BEST (Breastfeeding Education Support and Training) Services, Galway, Ireland

Infant and Young Child Feeding (IYCF) can be included in many areas of health policy – child health, women’s health, healthy hearts, and many others – as well as into overall health promotion strategies. It is possible to assume that nearly every aspect of a national health policy could have an effect on IYCF or be affected by decisions families make about IYCF.

Food industry – national (and regional) policies may provide financial subsidises to the breast milk substitute and baby food industry thus a barrier to increasing breastfeeding. On the positive side, the recent developments in the EU Commission on food and food safety may help to support the Code and optimal IYCF.

Economic policies – affect women’s involvement in employment, either with encouragements to participate in the workforce or to remain at home with children. Economic policies can also provide allowances to low-income women for food for themselves or their children. Economic issues arise in support in emergency situations. Donor education may be needed to avoid inappropriate supplies in emergency situations.

Workplace policies – need to safeguard maternity and lactation breaks by ensuring the breaks are not just allowed but are also taken by the women involved. Legislation needs to apply and be enforced in all sizes of companies.

Education policies – need to show good practices of IYCF in general images in schoolbooks as well as in specific subject material. Education for parenthood is important plus support for mothers who are students or trainees.

Social policies – include women and children’s rights. Supporting these rights help to support IYCF. The roles of fathers (and grandmothers) need to be considered and their support encouraged in order to support mothers.

Health service policies – include BFHI, education of health workers (including administrators), Code enforcement, and providing for special situations.

Integration into national policies may need:

- cross-sectoral involvement;
- national level coordination; and
- linkage to other programmes, including children’s rights.

10. BFHI – Lessons learned and ways to safeguard quality of care

10.1. BFHI – Lessons learned and constraints

Hind Khatib, UNICEF Regional Office for CEE/CIS and the Baltics, Geneva

UNICEF and the World Health Organization are working to promote breastfeeding through the Baby-Friendly Hospital Initiative (BFHI), which ensures that hospitals become centers of breastfeeding support. A hospital is designated as “baby-friendly” when it has agreed not to accept free or low-cost breast-milk substitutes, feeding bottles or teats, and to implement 10 specific steps to support breastfeeding. The initiative was launched in 1989. Since then, more than 14 000 hospitals worldwide have received the WHO/UNICEF “Baby Friendly Hospital” award, showing they have adopted practices to support successful breastfeeding.

A summary of various lessons learned by people who have been working on the BFHI, as well as constraints that are still perceived to limit the implementation of the BFHI, is presented in Table 10.1.

During this consultation, the participants were asked to share their experience with working with the initiative. While agreeing with the limitations and constraints presented (Table 10.1), they also reported some additional points. For example, it was mentioned that health care managers need to be convinced of the importance of the BFHI while health care workers need to be motivated to implement and/or sustain it. The participants also noted that the commitment of the people involved in the implementation process is usually strong and that the enthusiasm of the mothers is a very positive point.

Several participants reported that the lack of commitment of health care managers (sometimes due to frequent changes at the management level) was a major constraint to the implementation of the BFHI. Frequent changes in ministries of health were also perceived as a deterrent to governmental commitment. The participants felt that the importance of healthy nutrition was not understood by most governments and that there was a lack of enforcement of the initiative (no body controlling what should be enforced). The lack of staff, lack of knowledge and skills of health care workers, the negative attitudes and beliefs of health workers, and the difficulty in motivating staff were perceived as important constraints by several participants. It was also reported that in some countries health care facilities are in bad condition (some destroyed), while in others it appears that a high level of quality of care is hard to maintain. Finally, while the initiative supports breastfeeding in the hospital, it was perceived that there is often a lack of antenatal support programs and a lack of support to mothers who have returned home.

Table 10.1. BFHI – Lessons learned and constraints

Lessons learned	Constraints
<ul style="list-style-type: none"> • BFHI was launched as a global challenge • UNICEF’s commitment at top level • Advocacy speeches made by UNICEF ex-director and well known figures were crucial • Strong alliance and partnership with INGOs, NGOs, etc. • High level visits to countries • Relating the importance of breastfeeding to industrialized countries • Outlining the health and economic benefits • UNICEF’s direct involvement in planning and implementation • Creation of a healthy competition among hospitals • Improvement of quality of care in the hospital especially through the delivery process, thus hospitals become mother/baby friendly • Extending the BFHI principles to paediatric wards • Including PHC services in the training for BF/BFHI • Reaching out to the community through MSG, families/parents, work environment • Enhanced the different medical professions to understand and appreciate each others work • Breastfeeding is more and more recognized for its health and economical benefits to child, family, health structure, etc. • Early bonding of mother and baby is key to reduce the number of child abandonment • Rooming-in reduces workload of health staff • The number of ExDirs/PROs etc, which ensured BFHI stayed on the agenda of all offices • Letters signed by WHO/UNICEF to Heads of Governments • Availability of good training materials • Availability of well run courses in the world 	<ul style="list-style-type: none"> • BFHI is seen as UNICEF’s project • As it is organized as a project, it is harder to insure sustainability • Assessment process is costly • The approach used to achieve certification is rigid • BFHI is vertical in its approach • The Initiative was seen too rigid in its approach • Some steps were difficult to achieve, thus it dampened the spirits and energies of health workers • The title insinuated that hospitals are not friendly to babies • The deterioration in economy; more hospitals and health care professionals are becoming dependent on industry’s incentives; individuals of low socio-economic status are often easy victims of these incentives • UNICEF’s involvement is decreasing so is its financial contribution to breastfeeding promotion • WHO’s role in BFHI is minimum/ceremonial • Lack of governments’ commitment • Lack of funding

10.2. Monitoring and reassessment: tools to sustain progress

Randa Saadeh, WHO Headquarters, Geneva

In 1999, WHO and Wellstart International in collaboration with UNICEF made available a new tool using qualitative and quantitative methods for the monitoring and reassessment of the BFHI. This tool is designed to foster the involvement of hospital management and staff in problem identification and planning for sustaining or improving the implementation of the “Ten Steps to Successful Breastfeeding”. This strategy should contribute to long-term sustainability of BFHI and help ensure its credibility. Further on it encourages a global standard for maternity services.

The general aim of the tool is to encourage a global standard for maternity services. More specifically, the objectives of the tools are to:

- Enable mothers to make an informed choice about how to feed their newborns
- Support early initiation of breastfeeding
- Promote exclusive breastfeeding for the first six months
- Ensure the cessation of free and low cost infant formula supply to hospitals
- Include, possibly at a later stage and when needed, other mother and infant health care issues.

The monitoring and the reassessment tools have been developed for adaptation and use by countries that want to implement a BFHI monitoring or reassessment process. UNICEF and WHO encourage countries to develop systems for monitoring and/or reassessing hospitals that have been designated baby-friendly, as a strategy for maintaining the standards they have achieved. It is suggested that monitoring could take place every 6 to 12 months, with results comparing over years. Reassessment could take place every two or three years. The key users of the information would be Ministries of Health, certified Baby-friendly hospitals, BFHI or breastfeeding authority at country level, and BFHI coordinators.

The monitoring process can be organized by the hospitals themselves or at a higher level of the system. It should measure both the breastfeeding-support provided by the hospitals and the mothers’ current infant feeding practices. A total of thirty mother interviews are recommended over a time frame from one week to one month. But there is also a possibility for a shorter period of time and less interviewees. A minimum of ten staff interviews is suggested. It is important that the mothers are interviewed as close to discharge as possible, that they or their babies do not have medical problems that interfere with infant feeding. The proportion of mothers with vaginal and caesarean section deliveries could be the same as the proportion of those types of deliveries reported for the hospital for the last year.

The reassessment in the re-evaluation of already designated baby-friendly hospitals to determine if they continue to adhere to the Ten Steps and other baby-friendly criteria. It is usually planned and scheduled by the national BFHI authority for the purpose of on-going compliance with the global criteria and includes a reassessment visit by an outside team. It is often more comprehensive in scope than monitoring and usually involves the need for

additional resources. Because of the human and financial resources required, in many countries it may be feasible to reassess hospitals only once every two or three years. Results are usually sent by the assessors to the national BFHI authority, which in turn, informs the hospitals of the results.

Where implemented, the tool has been able to ensure quality and credibility of the baby-friendly process and sustain progress already achieved. Examples come from Oman, Malaysia, Brazil, China, and Kazakhstan.

11. Breastfeeding and HIV/AIDS

Viviana Mangiaterra, WHO Regional Centre for Europe, Copenhagen

There is currently a dilemma regarding breastfeeding and HIV transmission: without breastfeeding, HIV transmission is reduced; however, does this result in:

- Increased infant mortality and morbidity?
- Increased stigma?
- Does it undermine breastfeeding promotion among HIV-negative women or those with unknown HIV status?

As well there remains a question as to whether exclusive breastfeeding lowers transmission risk compared with mixed feeding or if it is at all feasible.

In view of the HIV dilemma, in October 2000, clarifications were made to the existing 1998 recommendations:

- Replacement feeding was recommended when this was acceptable, feasible, affordable, sustainable and safe.
- The mother should be guided in her choice towards the option most suitable for her situation.
- If the mother chooses to breastfeed, exclusive breastfeeding is recommended for the first months of life. Breastfeeding should be discontinued when an alternative form of feeding becomes possible.
- Whatever the mother's choice, she should be given all necessary support.

In the case that replacement feeding for infants born to HIV-positive mothers is promoted, the following is recommended that:

- mothers be able to provide (or be provided with) formula for exclusive replacement feeding during the first two years of infant life;
- it be ensured that mothers know how to prepare the formula; and
- other replacement feeding be considered, i.e., home made formula.

The promotion of formula feeding for infants born to HIV-infected mothers should not jeopardize programs for promoting breastfeeding for infants born to mother who are HIV-negative or of unknown status, as recommended by Baby Friendly Hospital Initiative and the International Code of Marketing of Breast milk Substitutes.

Further information on HIV and replacement feeding can be obtained through *HIV and Infant Feeding* (UNICEF/UNAIDS/WHO, June 1998); *Guidelines for decision makers; A guide for health care managers* <http://www.unaids.org/publications/documents/mtct/index.html>.

The following are the recommendations made to prevent MTCT after birth:

Avoid breastfeeding, using replacement feeding as follows. (a) from four to six months: commercial infant formula, home-made infant formula (diluted animal milk+sugar+vitamins); (b) from six months to two years: enriched family foods; exclusive breastfeeding and early weaning (as soon as replacement feeding is feasible and safe).

12. Code of marketing of breast-milk substitutes

12.1. Implementation of the code, its relation to the CRC and ways to improve the code of implementation

David Clark, UNICEF's Nutrition Section, UNICEF Headquarters, New York, United States of America

The draft Global Strategy document recognizes the importance of implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions in any strategy to improve infant and young child feeding. Parents and caregivers need good, accurate, unbiased information on infant feeding and breastfeeding, and need to be protected from misinformation.

The Code was adopted by the World Health Assembly in May 1981 to bring about this type of protection, but despite the fact that it was adopted as a global recommendation and a minimum standard, countries have been slow to implement it

The Convention on the Rights of the Child provides a legal framework within which to place States' obligations to protect, promote and support breastfeeding. As a legally binding treaty, it obliges governments to take "all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention"

States Parties to the CRC must take "appropriate measures" under Article 24 (e) "to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of "... the advantages of breastfeeding ..."

This means that States must take measures to protect all segments of society against misinformation, such as implementation of the Code. The Committee on the Rights of the Child, which monitors implementation of the Convention, recognizes the Code as an appropriate measure to be adopted.

What about HIV and emergencies? Does the Code still apply?

The Code is of extreme importance in these situations since it aims to: regulate the distribution of free or subsidized supplies of breast-milk substitutes to prevent spillover to babies who would benefit from breastfeeding. It also seeks to protect artificially fed children by ensuring that product labels carry necessary warnings and instructions for safe preparation and use, and that the choice of product is made on the basis of independent medical advice, and not commercial influence.

The Code vs. the EU Directive

The EU Directive on infant formula and follow on formula has weaker labelling requirements, than the Code, and only applies to infant formula and, to a limited extent, follow-up formula, and not to the wider category of breast-milk substitutes, feeding bottles and teats covered by the Code. The Directive permits the promotion of infant formula through advertising in specialist baby care and scientific publications, whereas the Code prohibits all advertising or other forms of promotion to the general public of all breast-milk substitutes, feeding bottles and teats.

Is adoption of the Code compatible with EU membership?

Yes. The EU Directive permits Member States to adopt more restrictive provisions on advertising, while stricter labelling requirements can be introduced on the basis that they are necessary to protect infant health.

What is needed to improve Code implementation:

- advocacy/awareness raising
- capacity building/training
- drafting expertise
- implementation, monitoring and enforcement

12.2. Monitoring the implementation of the Code – The Hungarian experience

Katalin Sarlai, Hungarian Association for Breastfeeding, Budapest, Hungary

The International Code of Marketing of Breast-milk Substitutes was unknown to the Hungarian people until the beginning of the 1990s. The Baby-Friendly Hospital Initiative (BFHI) helped publicize it. In 1994, the Hungarian Association for Breastfeeding (HAB) – IBFAN group - translated and published the International Code and the World Health Assembly's (WHA) resolutions in the Hungarian language. As a result, IBFAN Code monitoring training sessions were held in Prague and Bratislava, and local training sessions were held in Budapest. There are about 30 persons in Hungary who are well trained in the International Code and who monitor Code violations. Hungary was involved in the IMP II and a report was published by the HAB in 1997 to describe the state of the International Code implementation in Hungary. The report was published in Hungarian and English. The HAB used this report to support the implementation process of the Code. In 1998, formula regulations were prepared by the Ministry of Welfare. Participants in the preparation process included health care policy makers and baby food industry representatives.

12.3. Monitoring the implementation of the Code – The Slovak experience

Daniel Polakovic, Department of Paediatrics, Children’s University Hospital, Bratislava, Slovakia

Until recently no national law incorporating the principles of the International Code has been in power in Slovakia. Hence, no legal tools have been available to enforce the industry’s compliance with the Code. Therefore, a different approach was taken. An awareness raising campaign aimed at health workers has been launched, using two different channels for passing on the information. First, the chief paediatrician of Slovakia has forwarded to primary care paediatricians and neonatologist at least some basic information about the International Code, using the contacts of both the official health care system as well as the Slovak Paediatric Society. Second, the ProVita NGO spread the information to both paediatric practitioners and neonatologist of the Bratislava region, using both their personal contacts (most members of ProVita are paediatricians) as well as the occasion of a seminar on breastfeeding issues.

Well informed physicians are less likely to engage in or indulge to Code violations. This has proven to be a relative satisfactory method of counteracting the marketing efforts of the baby food industry. Marketing staff has not been allowed to come in direct contact with pregnant women and mothers, no advertising activities were allowed in maternity hospitals, no free samples have been distributed in maternity wards. Unfortunately, useful and/or decorative items bearing companies’ or brand names are still to be seen in hospitals (pens, nice posters of babies, wall clocks etc).

The responses of the primary care paediatricians to the above-mentioned efforts vary considerably from case to case. Pro Vita has attempted to “immunize” mothers against the negative impact of marketing campaigns by informing them about the Code related issues (relevant information included both in leaflets distributed in Bratislava’ s maternity wards as well as on the ProVita web site).

Monitoring – currently performed only by ProVita:

- passive – hints from our colleagues, members of the mother support group, visitors to our website etc; and
- active – the above mentioned plus active outreach to our colleagues at various maternity hospitals.

Current situation:

- improper labelling – wide spread
- advertisements – leaflets available both at supermarkets and pharmacies
- health professionals and parents targeted magazines – contain a large number of ads, frequently violating the Code. However, no advertisements in general press and electronic mass media
- interactions of health professionals and the Industry – frequent, baby milk industry co-sponsors most paediatric meetings in Slovakia

A new law was passed in Slovakia recently (Nr.147/2001 §9-11). It is based on the EU – directive:

- it prohibits the use of words like “maternalized”, etc
- it prohibits the use of graphic and text elements implying that artificial feeding may be equal or superior to breastfeeding
- requires that information on the superiority of breast-milk and the risks related to bottle feeding be mentioned
- prohibits advertising breast-milk substitutes in media other than health professionals and parents targeted magazines

The Institute of Drug Surveillance (Statny ustav kontroly lieciv) is in charge of monitoring the industries compliance with the above-mentioned law. The penalties include the ban of the relevant advertisement, public denial of incorrect statements, a fine of up to SKr 2 000 000 (≈US \$40 000).

13. Maternity legislation: Experiences from Norway

Bodil Blaker, Ministry of Health and Social Affairs, Oslo, Norway

A long paid maternity leave and paid breastfeeding breaks are considered important measures to the high breastfeeding rates in Norway. The National Insurance Act (1) and the Norwegian Working Environment Act (2) regulate maternity leave and breastfeeding breaks.

In 1993 the duration of the maternity leave was prolonged from 20 weeks to 42 weeks fully paid or 52 weeks with 80% pay. This is a right for all parents that have been in paid employment for at least six out of the last ten months before delivery. The amount of the pay is decided according to the salary the mother (or father) has in her job. According to these rules, some women are not entitled to paid maternity leave. These women receive a maternity grant of about NKr 32 000.

Except the first six weeks of the maternity leave, which is compulsory for the mother, the parents can decide which one of them will stay at home during the leave of absence. The father has the same rights as the mother to paid maternity leave, if he is the one of the parents that shall stay at home. From 1993, four weeks as a share of the total maternity leave, are reserved for the father.

During the first two weeks after delivery, the father is entitled to stay home to take care for the mother and the baby. These weeks may be paid or not, depending on the agreement between the father and his employer.

When mothers go back to work, they can have at least 30 minutes twice a day as breastfeeding breaks. Whether these are paid or not depends on agreements between the employer organisations and the labour unions. Most women in Norway have paid breaks because they are covered by such agreements.

In 1994 the system called “time account” was introduced. This means that employees are entitled to partial leave of absence combined with fractional payment of maternity benefits. The parents can choose to work part-time and in this way extend the maternity leave (except the three weeks before delivery and the first six after, plus the four weeks for the father) over two years.

In this abstract it is possible to give only a brief overview of the regulations. It must be remembered when referring to them that they are much more detailed than described here.

References:

1. The National Insurance Act of 28. February 1997 no 19 with amendments, last of 21 December 2000 no 125.
2. Act No. 4 of 4 February 1977 relating to Worker Protection and Working Environment

14. Working Groups

Group work sessions

During the consultation, participants were invited to contribute to three working group sessions to discuss (a) the content of the Global Strategy, and (b) the development of a comprehensive and integrated Infant and Young Child nutrition policy.

Participants worked in six sub-regional groupings:

- Baltic countries (Estonia, Latvia, Lithuania)
- Central Asian Republics and Commonwealth of Independent States (Kazakhstan, Kyrgyzstan, Moldova)
- Countries of Central Eastern Europe (Czech Republic, Slovakia)
- Hungary
- Nordic countries and Southern European countries (France, Israel, Italy, Norway)
- South East European countries (Bosnia and Herzegovina, Bulgaria, Croatia).

14.1. Working groups 1 and 2: Content of the global strategy, sustaining interest, government commitment to *Innocenti Declaration*, and new possible targets

In Working Groups 1 and 2, the participants discussed the ten sections of the Global Strategy as well as its additional operational targets. A summary of the discussions follows. Details of the comments/recommendations made by sub-regional grouping can be found in Appendix 4.

Introduction and overall aim of the Global Strategy (Sections 1 and 2)

The participants commented on the introduction and overall aim of the Global Strategy. Although the introduction was generally perceived to be clear, several regional sub-groups proposed additions that could make it more relevant to Europeans. Among others, it was suggested that details of the relationship between early nutrition and chronic diseases could be added, as well as details related to micronutrient deficiencies.

There was general agreement that the overall aim of the Strategy was relevant. However, one sub-region suggested that it should be accompanied by measurable objectives. In order to insure the appropriate distribution and application of the Strategy, it was also proposed that more attention should be given to the legislation of institutional rights, the monitoring of changes, and capacity building of health care providers. The reluctance of the medical community to accept updated information and practices was perceived by several participants as an important issue that could limit the application of the Strategy.

A summary of the recommendations made in relation to the introduction and overall aim of the Global Strategy is presented in Table 14.1.

Table 14.1. Summary of recommendations related to the introduction and overall aim

Introduction	<ul style="list-style-type: none"> • More details on the link between early nutrition and chronic disease could be added for a better relevance to the Region as a whole. • More attention could be paid to micronutrient / vitamin deficiencies and not only to malnutrition in general. • Details of the International Conference on Nutrition could be included in the introduction (as it is referred to in the conclusion).
Overall aim	<ul style="list-style-type: none"> • The aims should be linked with measurable and accountable objectives. • More attention should be placed in the legislation of institutional rights and their power to the maternity health care providers. • The extent of changes should be monitored and analysed. • More emphasis could be put on the importance of capacity building of health professionals in consistence with international recommendations.

Feeding guidelines (Sections 3–6)

The feeding guidelines and the positive approach used in the Strategy were viewed favourably by each sub-regional group. The guidelines were generally thought to be clear, sufficient, and well organized. Nevertheless, small changes were suggested (as described below) and one group proposed that more details on complementary feeding could be included.

The “Rights based approach” was perceived as suitable and useful. Some participants believed that the Strategy should stress the fact that governments should include in their policy documents the rights to obtaining full and adequate information. Others would like to see more details of the responsibilities of health professionals. It was suggested that the

obstacles to the fulfilment of the rights should be described, and advocacy from international organizations such as WHO and UNICEF should be provided to facilitate the implementation (and sustainability) of the Strategy.

The participants believed that there were a few omissions in the Strategy. These included the effect of drugs, alcohol, and smoking, the importance of early child-mother bonding, and the importance of well-organized, accessible and continuous support (individual and group support) and follow-up of mothers. In addition, it was suggested that details of non-discriminative policies on how to support mothers (and families) who have contraindications to breastfeeding or have failed in breastfeeding should be provided.

The re-affirmation of the *Innocenti Declaration* was perceived to be relevant. The priorities included in the Strategy were thought to be correct and described with suitable emphasis. Some regional sub-groups believed that a realistic schedule of achievements of the operational targets should be presented to governments and that it was important to set goals.

There was a general perception that obligations and responsibilities had been appropriately identified in the Strategy. However, some participants would have liked to see more emphasis on the responsibilities of health professionals. Others suggested that the role of the governments' institutions in charge of monitoring should be stressed further. Putting more attention as to who should ensure individuals' rights was also perceived as necessary by one regional sub-group.

Overall, the strategy was perceived to be coherent and useful, particularly, as mentioned by some country representatives, if governments are sincerely interested. It was suggested that governments should propose their own action plan and account for them.

Finally, it was generally agreed that a summary document of the Global Strategy would be a useful tool for submission to policy makers.

Suggested changes to Sections 3 to 6 of the Strategy are listed in Table 14.2.

Table 14.2. Summary of suggested changes related to the feeding guidelines

Clarity, structure and level of details	<ul style="list-style-type: none"> • More details should be added to the section on complementary feeding.
Use of a positive approach	<ul style="list-style-type: none"> • Examples of “what <i>not</i> to do” could complement the positive approach used. • Adding emphasis on the implementation of already accepted responsibilities of signatory countries would be useful.
“Rights based approach”	<ul style="list-style-type: none"> • State’s policy documents should describe the procedure of family rights to obtaining full and adequate information. • The individual ethical responsibilities of health professionals should be stressed. • The rights based approach should not be used with an empty meaning. • The objective obstacles to the fulfilment of rights should be described. • Advocacy from respected international organisations should be provided (e.g. WHO and UNICEF)
Omissions	<ul style="list-style-type: none"> • Details of support to mothers (and the families) who have contraindications to breastfeeding or have failed in breastfeeding (non-discriminative policy concerning them) • Section on families with drug consumption • Description of the importance of well-organized, accessible and continuous support (individual or group support) and follow-up of mothers • Details of the importance of early child-mother bonding • Details of the effects of drugs, alcohol, smoking
Content	<ul style="list-style-type: none"> • The operational targets should be presented with a realistic schedule of achievements for the governments. • It is important to set goals. • It might be useful to refer to the World Summit for Children’s goals.
Obligations and responsibilities	<ul style="list-style-type: none"> • The obligations and responsibilities of professionals could be stressed more. • The role of governments’ institutions in charge of monitoring, analysis and follow-up could be stressed further (financial support is essential for the program sustainability). • More attention could be place in describing who should ensure the rights and how this should be done.

Operational targets (Section 7)

The operational targets (and additional targets) were perceived as very useful by the participants. One sub-group mentioned that they would be particularly good for advocacy at the government level and for the development of intersectoral collaboration. Another group said that the firm statement on duration of exclusive breastfeeding was a strength and that the additional targets would provide opportunities for putting more emphasis on complementary feeding, for the inclusion of exceptional circumstances that are not covered by other existing policies and strategies, and to improve existing local infant and young child feeding strategies.

Various omissions were reported by the different sub-groups (see Table 14.3). These are related to both the *Innocenti Declaration* targets (Point 7.1 in the Strategy) and the additional operational targets (Point 7.3). In addition to the suggested changes listed in Table 14.3, one group proposed that if breastfeeding and nutrition are indicators of the quality of health care services, governments should change the standards of maternity care. In order to set priorities, health care services implementing the BFHI should be regarded as providers of better (higher quality) maternity services and should be better supported by governments.

From their experience of working towards the operational targets identified in the *Innocenti Declaration*, the participants reported having learnt several lessons. The main lessons are that resources (human and financial), information and skills are often lacking, and the fact that it is realistically very difficult to achieve completely all targets. One sub-group also suggested that the BFHI principles should be included in paediatric and community-based services.

The sub-groups agreed that setting a target date for the implementation of the additional targets is important. However, some participants felt that if the target date was too distant in time, the governments in place would not feel involved. To help resolve this problem, some participants suggested that the governments should describe the implementation dates for the strategy using a step-by-step procedure with shorter time periods (continuous progress with a set of gradual goals). Others recommended that some flexibility might be required when deciding on a target date to allow variation among countries (different national situations). The suggested target dates ranged from 2005 and 2010. One group suggested that it might be necessary to also decide on target dates for the assessment of the progress done in implementing the Strategy. During the general discussion, a consensus was reached that a period of approximately 10 years would be reasonable for achieving the implementation of the Strategy. However, reports on the progress made in implementing the Strategy should be made earlier.

The participants discussed whether they agreed with the fourth additional target, that is: “to develop guidelines on appropriate feeding of infants and young children and on the support required by their mothers and caregivers in **exceptionally difficult circumstances**”. There was general agreement that this is a very important target. One sub-group stressed that ensuring food security for all is essential. Another group suggested that the term “exceptionally difficult circumstances” could be replaced by “special circumstances”, to relate it not only to social circumstances but also to special health and environmental situations.

Finally, the participants suggested that a few other groups and situations could be added in the operational targets. These are listed in Table 14.3.

Table 14.3. Summary of suggested changes related to the operational targets

Omissions	<ul style="list-style-type: none"> • Representatives from local communities should also be included in the multisectoral national breastfeeding committee. • The <i>Ten Steps to Successful Breastfeeding</i> should be provided by maternity services AS WELL AS paediatric units and the community. • The rights of ALL women (not only working women) should be protected. • There is no stated target for maternity leave. • National legislation should be adopted to follow-up on the ILO-convention. • There is no mention of the importance of ante-natal support. • There is no specific mention of families in difficult socio-economic situations. • A new target could be to “ensure that when a woman chooses not to breastfeed her child, she must be supported by professional health workers”. • A new target could be to “mobilize the civil society”.
Other groups or situations that need to be added	<ul style="list-style-type: none"> • Hospitalized individuals. • Optimum nutrition for women of childbearing age, before pregnancy, during pregnancy (antenatal support) and during lactation.

Components of a comprehensive policy (Section 8)

Participants commented on the section of the Global Strategy (Section 8) that discusses the required components of a comprehensive policy and related plan of action for achieving the operational targets and creating environments that protect, promote and support sound infant and young child feeding practices. One sub-group mentioned that the structure (legislation, financing systems, infrastructure, training courses, staff), process and outcomes (monitoring and feedback) should be described in a comprehensive policy. Another sub-group suggested that local (national) adjustments would need to be made in a comprehensive policy in order to reflect particular circumstances.

Monitoring was perceived as of major importance by the sub-groups (see Table 14.4). The participants felt that there was currently a lack of definitions of standards for monitoring systems and for indicators of breastfeeding and nutrition policy (e.g., standards for maternity services according to the various aspects of breastfeeding and nutrition). One sub-group stated that this should be the responsibility of the governments.

One group stressed that the Strategy should suggest that countries should try to avoid the creation of new bodies for the implementation of the Strategy. They should instead build on existing ones and go to terms of reference of existing coordinators.

Other suggested changes to Section 8 are listed in Table 14.4.

Table 14.4. Other suggested changes related to the components of a comprehensive policy

Components of a comprehensive policy	<p>Monitoring</p> <ul style="list-style-type: none"> • Uniform (international) indicators for monitoring need to be developed. • Capacity building is needed at the country level in order to be able to develop adequate monitoring systems. • The monitoring of the expertise achieved through the education of health care professional should be included in the monitoring system. • Incentives to appropriate feeding practices should be included. • Where the BFHI is not well implemented, other initiatives (similar to the BFHI) could be used as a first step towards achieving the BFHI requirements. As well, the BFHI could include a step-by-step approach (different levels of achievement). <p>Other suggested additions/changes</p> <ul style="list-style-type: none"> • Governments should elaborate emergency nutrition plans that are acceptable to all health care workers. • It would be important to suggest governments to try not to create new bodies if the policy can be integrated into existing bodies. • Governments should be responsible for achieving a certain number of consultants per 1 000 births. • It should be specified that the use of micronutrient supplements should be recommended for serious reasons in case that healthy foods are not available. • The choice of local foods should depend on the target age group.
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Obligations and responsibilities for achieving operational targets (Section 9)

The obligations and responsibilities of governments and the civil society for achieving the operational targets were discussed. A summary of the discussion is presented in Table 14.5.

Most comments were related to the obligations and responsibilities of national governments. There was general agreement that governmental obligations and responsibilities should be stressed further in the Strategy, and that governments should not only adopt a comprehensive policy but also take the required actions to implement it. Again, the development of monitoring systems to assess progress came as an important issue.

Table 14.5. Summary of the discussion related to the obligations and responsibilities for achieving the operational targets

<p>Obligations and responsibilities for achieving the operational targets</p>	<p>National governments</p> <ul style="list-style-type: none"> • There should be more specifications of the obligations and responsibilities of national governments. The obligations of governments should make specific reference to: the implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions, the ratification and implementation of the ILO Convention on strengthening and sustaining of the BFHI. • There should be more collaboration between governments, civil society, non-governmental organizations, etc. • Different government levels and ministries should be involved (e.g., health, education, etc.) • Governments should not only adopt a comprehensive policy covering all the aspects of the strategy but also approve appropriate legislation for the implementation of this strategy in the national health care system and community based facilities in the most objective way. • Political will may be lacking. <p>Civil society</p> <ul style="list-style-type: none"> • Among the civil society groups, labour unions and consumer organisations should be added. • Monitoring the quality of the health services provided is important. <p>Other comments</p> <ul style="list-style-type: none"> • The international society must also feel responsible. • International standards for the evaluation of the extent of progress would be useful. • Among the critical moments of contact, prenatal care and home visits may be required.
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Conclusion

Few comments were made on the Conclusion section of the Strategy. One sub-group mentioned that a strong point of the conclusion was that it referred to the World Declaration and Plan of Action for Nutrition and that it highlighted the fact that child health is the basis for the development of any country.

Glossary of terms

The glossary of terms was perceived as a very useful tool. Some representatives suggested that it could be placed at the beginning of the document. Others mentioned that additional terms could be added to the glossary, including: “caregiver”, “exceptionally difficult circumstances”, “life cycle approach” and “optimal infant feeding”.

14.2. Working group 3: How to put the global and European IYCF strategies into the context of the European Food and Nutrition Action Plan

During this working group, participants were invited to list the actions necessary to bring about desirable improvements in infant and young child nutritional health, including improved growth and development. They needed to describe the actions required to harmonise inter-sectoral policies and to develop a more comprehensive and integrated approach to infant and young child nutritional health. Further details can be found in Appendix 4 (Table A4.3).

15. Practices, policies and programmes on infant and young child feeding

All participants in the consultation were asked to complete a short questionnaire on practices, policies and programmes on infant and young child feeding. The results from this questionnaire are described in Annex 5.

16. Conclusions and recommendations

There was general agreement that the Global Strategy would be a major tool to help improve infant and young child feeding practices in the European Region and thus the health of the population. The participants felt that the Strategy would provide a consensus on how to move forward in the area of infant and young child health, and that it could act as a model to help Member States develop high quality national infant and young child nutrition policies and action plans. It was suggested that the Strategy could increase the profile of infant and young child feeding at the highest political level and encourage governments to see the links between nutrition and health in infant and young children. It was suggested that the implementation of the Strategy could fall under the umbrella of national action plans based on the First Action Plan for Food and Nutrition Policy for the WHO European Region (2000-2005).

In general terms, participants believed that the Strategy was coherent and that the guidelines were generally clear and well organized, although some participants felt that some sections could be modified to make them more relevant to the European Region. The 'Rights based' approach used, the reaffirmation of the *Innocenti Declaration*, and the operational targets were viewed favourably by the participants.

A series of specific changes were recommended by the participants (as described in Section 14). However, general discussions emphasized the need to make responsibilities of governments more precise and concrete, and in particular to pay more attention to the legislation of rights, the implementation of international instruments, the monitoring of progress in the implementation of the strategy, the monitoring of changes in infant and young child feeding practices (using standardized uniform indicators throughout the Region – these would need to be developed), and capacity building of health care providers. The participants felt that governments should not only adopt a comprehensive strategy but also take the required actions to implement and sustain it. It was also suggested that advocacy from international organizations such as WHO and UNICEF should be provided to facilitate the implementation (and sustainability) of the Strategy. Obtaining political commitments was perceived as a major barrier throughout Europe to the implementation and sustainability of

the Strategy. In some regions, the lack of information and skills and the reluctance of the medical community were also described as major limitations. More generally, the participants felt that cultural and social issues could also act as barriers to the application of the Strategy.

Finally it was suggested that a short version of the Global Strategy would be useful for submission to policy makers.

Annex 1. Draft Global Strategy for Infant and Young Child Feeding Developed Jointly by WHO and UNICEF

(Note: words with asterisk appear in the proposed Glossary)

1. The challenge

1.1. Malnutrition is responsible, directly or indirectly, for half of the 10.5 million deaths each year among children under five years of age. Two-thirds of these deaths occur during the first year of life, and are closely associated with poor breastfeeding and poor complementary feeding* practices. Only a minority of infants worldwide are exclusively breastfed during the first months of life, and an estimated 1.5 million children die every year because they are breastfed only partially, or not at all. Very often, complementary feeding begins too early or too late, and is nutritionally inadequate and unsafe. Malnourished children who survive suffer increased morbidity, impaired development and reduced school performance. Poor feeding practices and their consequences, because they are a major threat to social and economic development, remain a major public health challenge.

1.2. The nutrition of children is of such importance that it is one of the key elements of the child's right to health as defined in the Convention on the Rights of the Child.* Children have the right to adequate nutrition, and access to safe and nutritious food; these elements are essential for fulfilling children's right to the highest attainable standard of health. Furthermore, women have the right to decide how to feed their children, and to full information and appropriate conditions that support their decisions. These rights are not yet realized everywhere.

1.3. Among the main difficulties that persist are:

- insufficient political will and commitment to meet the needs of infants and young children for appropriate feeding and care;
- cultural, health and medical beliefs, which may interfere with good feeding practices, including the idea, reinforced by commercial interests, that the use of breast-milk substitutes is "normal";
- insufficient awareness and demand for information, so that the majority of people remain unaware of the value of exclusive breastfeeding and of what constitutes good complementary feeding – when to start, what to give, how much, how often, and how to prepare and feed safely;
- non-supportive – and often obstructive – medical procedures, and other inappropriate health care practices, for example separation of mothers and babies after birth, and routine and medically unjustified use of breast-milk substitutes (glucose solution, infant formula);
- inadequate training of health workers, who receive too little preservice instruction about infant feeding, and who subsequently work in non-supportive health care environments;

- non-supportive workplace environments, where there are no breastfeeding breaks, or facilities for feeding infants or expressing breast milk; and
 - aggressive marketing of commercially prepared foods, at the expense of breastfeeding and home-prepared complementary foods.*
- 1.4.** Global social and economic change, which has a direct impact on households, makes it more difficult for families to feed and care for their children. Increasing urbanization results in more families being dependent on informal or intermittent employment, with uncertain incomes and few or no maternity entitlements*. In most countries rural, self-employed, and nominally unemployed women also have heavy workloads and usually no maternity benefits. While protective family and community structures are being eroded, resources to support health services – particularly nutrition-related activities – are diminishing.
- 1.5.** The HIV* pandemic, with the risk of mother-to-child transmission of infection through breastfeeding, has undermined the resolve of many governments to promote breastfeeding, even among unaffected families. For families that are affected, finding adequate sustainable alternative methods of feeding an infant can be impossible.
- 1.6.** Major emergencies of all types are increasing in number and intensity the world over, and the number of infants and young children whose care and feeding are compromised rises accordingly.

2. Aim of the strategy

2.1. The aim of this strategy is:

- to improve the feeding of infants and young children by:
 - protecting, promoting and supporting optimal feeding practices;
 - empowering all mothers, families and care-givers to make, and carry out, fully informed decisions about feeding, free from adverse commercial influences and misinformation; and
 - ensuring conditions that support exclusive* and continued* breastfeeding, and timely, adequate, safe, and appropriate complementary feeding, for every child.
- to increase the commitment of governments, civil society* and international organizations to protecting, promoting and supporting optimal infant and young child feeding, by raising awareness of the main problems, and approaches to their solution, taking into account prevailing social, cultural and environmental circumstances.

2.2. The strategy¹ is based on accumulated evidence of the significance of the early years for child growth and development. The strategy, which identifies specific interventions with proven positive impact on feeding practices and healthy growth and development, is intended as a guide for action. It demands respect, protection, facilitation and fulfilment of every mother's right to decide how to feed her infant, and the right of every child to have access to safe and nutritious food consistent with the right of everyone to be free from hunger.

2.3. No single intervention or actor can address all these challenges. There is thus an urgent need for increased political will, public investment, family and community involvement, and collaboration between governments, international organizations, and appropriate civil society groups to take the multiple actions required.

3. Optimal infant and young child feeding*

3.1. To achieve optimal growth, development and health, infants should be exclusively breastfed for the first six months of life. Thereafter, to meet their evolving nutritional requirements, infants should begin to receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.

3.2. Breastfeeding

3.2.1. Breastfeeding remains the unequalled way of providing ideal food for the healthy growth and development of infants and is an integral part of the reproductive process. Breast milk provides all the energy and nutrients that the infant needs for the first months of life, and it continues to provide up to half or more of a child's nutritional needs during the second-half of the first year, and up to one-third during the second year of life. It promotes sensory and cognitive development. Breast milk contains unique immunological properties which protect against both infectious and chronic diseases. Breastfeeding's positive contribution to the health and well-being of mothers, child-spacing, family and national economics, food security and a safe environment makes it a key aspect of primary health care and an important aspect of sound socioeconomic development.

3.2.2. Accumulating evidence also demonstrates that:

- exclusive breastfeeding from birth is possible except in the case of a small number of specific medical conditions (Annex 1), and unrestricted* exclusive breastfeeding from birth results in ample milk production;
- breastfeeding, while a natural act is also a learned behaviour. Virtually all women can breastfeed provided they have adequate information and support, and, if needed, skilled practical help, for example from breastfeeding counsellors*, who can help build mothers' confidence, improve technique, and prevent or resolve difficulties;

¹ This strategy takes into account the background documentation and discussions at a Technical Consultation on Infant and Young Child Feeding held in Geneva in March 2000.

- women in paid employment can continue to breastfeed successfully provided they benefit from enabling conditions, for example paid maternity leave, part-time work, workplace facilities (on-site crèches, facilities for expressing milk), and breastfeeding breaks. Conditions which facilitate continued breastfeeding also benefit employers since they reduce employee turnover and absenteeism due to child illness;

3.3. Complementary feeding*

The period when complementary foods are introduced is crucial to child health and development. Children are particularly vulnerable during this transitional period, and if their needs are not appropriately met, malnutrition and disease will follow. It is essential that complementary foods are introduced at the right time (*timely*), that they are nutritionally adequate (*adequate*), that they are hygienically prepared and fed (*safe*), and that they are fed responsively and in sufficient quantity (*appropriately fed*). In this context:

- *Timely** means that foods are introduced when a child's need for energy and nutrients exceeds what can be provided by exclusive and frequent breastfeeding. Health risks increase when complementary foods are given earlier or later than necessary. Complementary foods should be introduced before six months only if an infant is not gaining weight, or is clearly hungry, despite well-supported and unrestricted breastfeeding; or if an infant shows interest in complementary foods, for example by actively reaching for them.
- *Adequate* means that foods are sufficiently rich in energy, protein and micronutrients to meet a growing child's nutritional needs. Good complementary foods can usually be prepared using locally available ingredients that are culturally, socially and economically acceptable. They are prepared in a consistency suitable for the young child to eat and digest, during the transition to usual family foods.
- *Safe* means that foods are hygienically prepared and stored, fed with clean hands and clean utensils, and not fed by bottle.
- *Appropriately fed* means that caregivers are responsive to a child's signals of appetite and satiety, and that meal frequency and feeding method (spoon, fingers, aided by a caregiver or self-feeding) are suitable for the child's age. Infants 6 months to 1 year of age should receive three additional meals when breastfed, or five meals when not breastfed. Children 12-24 months should receive at least five meals daily, in addition to breast milk. From two years of age onwards, children are able to eat ordinary family foods, three times a day, with the addition of a nutritious snack twice daily. Caregivers should also actively help a child consume a sufficient quantity of food, through encouragement, play and attention during a meal, which is described as active or responsive feeding.

3.3.2. Accumulating evidence shows that:

- In many settings, inadequate knowledge about food and feeding practices is a more important determinant of malnutrition than is the lack of food.
- As with exclusive breastfeeding, appropriate complementary feeding practices require accurate information and skilled support from the health system and within communities.
- Feeding provides a key opportunity to care for the developing child. Active or responsive feeding is a crucial aspect of good feeding practice, and an important element of psycho-social stimulation for the child.
- Ensuring adequate amounts of micronutrients – especially vitamin A, iron, zinc and iodine – through a normal family diet can be a challenge in some environments. Interventions such as food fortification, and universal or targeted supplementation may be required in addition to the promotion of appropriate complementary foods.
- The safe preparation of adequate complementary foods in the home can be time consuming and resource intensive, and therefore place a strain on families and communities. The production of low-cost processed foods can be an important means to alleviate these difficulties, provided they are subject to adequate quality control measures.
- Industrially prepared food products can provide an option for some mothers who have the means to buy them and the knowledge and facilities to prepare them safely for their children. However, families should be protected from adverse commercial influence and misinformation.

4. Other feeding options

4.1. Artificial feeding

4.1.1. Artificial feeding – giving a breast-milk substitute, whether totally or partially – increases the risk of illness, poor growth and development, and malnutrition. Infants should be fed artificially only when this is unavoidable, for example in the case of death or prolonged absence of the mother (see Annex 1).

4.1.2. The vast majority of mothers can and should breastfeed, just as the vast majority of infants can and should be breastfed. Only under exceptional circumstances can a mother's milk be considered unsuitable for her infant. For those few health situations where infants cannot, or should not, be breastfed, the choice of the best alternative – whether it be expressed breast milk from the infant's own mother, breast milk from a wet-nurse or a breast-milk bank, or a breast-milk substitutes – depends on the particular circumstances.

4.1.3. Even when correctly prepared and fed, nutritionally adequate breast-milk substitutes still:

- lack the quality and balance of the nutrients provided by breast milk;
- lack the protective factors of breast milk against infectious and chronic disease;
- are associated with lower scores on tests of mental development in infancy and childhood;
- entail additional economic costs in time, fuel, water, infant formula, and care for extra illness;
- are often unsustainable for households with limited incomes.

4.1.4. When artificial feeding is unavoidable, families should receive the assistance necessary to give artificial feeds as safely as possible. If non-breastfed children are to survive and develop well, their increased risks must be compensated for by extra attention and investment of resources by families, health care systems, and nations.

4.1.5. Infants who are not breastfed require a suitable breast-milk substitute* for the first six months of life, followed by adequate complementary foods and continued milk feeding up to the age of two years or beyond. If milk is not available after six months, appropriately prepared family foods should be further enriched and given five times a day to ensure sufficient total nutrient intake.

4.1.6. Cup-feeding is cleaner and safer than bottle-feeding, and it can be used from birth. Cup-feeding requires close adult contact and attention to a baby's needs, and it enhances the emotional bond between caregiver and infant. Feeding bottles are dangerous and unnecessary.

4.2. Replacement feeding*

The term "replacement feeding" is used to describe feeding of infants whose mothers have tested positive for HIV, and who, after counselling, choose not to breastfeed. It refers to the process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients the child needs. During the first six months, this should be with a suitable breast-milk substitute – commercial (generic or proprietary) infant formula* or home-prepared formula* with micronutrient supplements*. After six months it should preferably be with a suitable breast-milk substitute and complementary foods made from appropriately prepared and nutrient-enriched family foods, given three times a day. If suitable breast-milk substitutes are not available, appropriately prepared family foods should be further enriched and given five times a day.

5. Feeding in exceptionally difficult circumstances

5.1. There are a number of exceptionally difficult situations where families need special attention and psychosocial support to feed their children adequately. In such cases the likelihood of not breastfeeding, and the dangers of artificial feeding* and inappropriate complementary feeding, are increased. The rights of children and

women in these situations also need to be respected, protected, facilitated and fulfilled.

In these situations, whenever possible mothers and infants should be kept together and given extra help:

- to breastfeed exclusively infants who are below 6 months, or to re-establish exclusive breastfeeding if this has been interrupted;
- to give adequate complementary foods to infants older than 6 months, and to continue unrestricted breastfeeding;
- to arrange a wet-nurse, if possible, when a mother is not available, or to help a caregiver to feed the baby artificially as safely as possible.

5.2. Exceptionally difficult circumstances include the following challenges of :

5.2.1. Infants who are born pre-term or with low birth weight

The proportion of infants born with low birth weight varies from 7% to over 30% in different settings. Breast milk for these infants is at least as important – and possibly more so – as for term infants with acceptable weight. Most of these infants are born at or near term and can breastfeed within the first hour of birth.

Breast milk is particularly important for pre-term infants and a small proportion of term infants born with very low birth weight who are at increased risk of infection, death, and long-term ill health. Although very pre-term (<34 weeks) small infants (<2000 g) can feed directly from the breast soon after birth, they may have difficulty obtaining enough milk for the first few weeks of life.

Until an infant can obtain sufficient breast milk by suckling, supplements of expressed breast milk can be given by cup. Skilled help is required to enable women to express their milk and to feed it effectively and often to their low-birth-weight infants. Health workers should be trained and deployed to provide this help. If initially mothers of pre-term or low-birth-weight infants cannot provide sufficient amounts of their own breast milk, pasteurized breast milk from another lactating woman or a breast-milk bank, or infant formula can be used until breastfeeding has been established.

5.2.2. Infants and young children who are malnourished

Malnourished infants and young children most often come from environments which do not readily provide optimal nutrition, and where it is particularly difficult to improve the quantity and quality of children's food intake. Extra attention is needed in such circumstances, not only during the early phase of rehabilitation, but also over the long term to prevent recurrence and to minimize malnutrition's chronic effects, for example stunting. The support of health care and community workers for the families and other caregivers concerned needs to be both intensive and sustained.

The families of these children may find it particularly difficult to obtain nutritionally adequate and microbiologically safe complementary foods. Dietary supplements should be provided.

Continued breastfeeding and, when necessary, re-lactation, are important in this context, since inadequate or disrupted breastfeeding both contribute directly to malnutrition. Re-establishing breastfeeding is of particular value when malnutrition occurs during the first 6 months of life. It is also valuable after 6 months as a contribution to maintaining intake of good quality nutrients, especially when foods of animal origin are scarce. Moreover, breast milk helps to prevent and overcome infections in children whose resistance is lowered due to malnutrition

- 5.3.** Major emergencies following in the wake of natural or human-induced disasters – including drought, floods, earthquakes, war, civil unrest and severe political and economic decline – dramatically change living conditions. The number of people affected has risen tenfold in the last decade, and young children are among the most vulnerable groups. Interruption of breastfeeding and inappropriate complementary feeding are common, increasing the risks of malnutrition, illness and mortality. Uncontrolled distribution of breast-milk substitutes, for example in refugee settings, may lead to early and unnecessary cessation of breastfeeding*.
- 5.4.** For the vast majority of infants in emergencies, the emphasis should be on protecting, promoting and supporting breastfeeding and ensuring adequate complementary feeding. The small number of infants who may require breast-milk substitutes need to be carefully identified and they, and those who care for them, given practical assistance and support.
- 5.5.** Families living with HIV. It is estimated that 1.6 million children are born to HIV-infected women each year, mostly in developing countries. Globally, the risk of mother-to-child HIV transmission through breastfeeding is between about 10% and 20% if the infant breastfeeds for two years. On the other hand, there is also a risk of sickness and death from diarrhoea and other illnesses for infants who do not breastfeed.
- 5.6.** Therefore, mothers who are tested HIV-positive, and where possible their families and partners, need counselling* to enable them to make a choice that is appropriate to their specific circumstances. This should consist of a discussion of the risks and costs of a range of feeding options, which may include exclusive breastfeeding with early cessation* to reduce the risk of HIV transmission; heat-treatment of expressed breast milk; wet-nursing by an HIV negative woman; and replacement feeding with commercial formula (whether bearing a proprietary brand or generic label) or home-prepared formula. They also need help to breastfeed exclusively if that is their choice; or to give replacement feeds, as safely as possible, preferably without using a bottle, and follow-up support for at least two years.
- 5.7.** For mothers who test HIV-negative, and for those who are untested the safest option is to breastfeed, and these mothers also need counselling and support, to reduce the risk of “spillover”* of artificial feeding to the general population.

5.8. Children living in special circumstances also include:

- those who are orphaned or in foster care,
- from mothers who have physical or mental disabilities,
- from mothers who are affected by drug or alcohol abuse,
- from mothers who are in prison,
- from mothers of marginalized socioeconomic groups, for example migrants workers, displaced persons and disadvantaged minorities.

5.9. Adolescent mothers may also need help to enable them to continue schooling, if possible, while breastfeeding and developing a strong emotional bond with their infants. Fathers, too, may need assistance to become involved in the care of their child.

6. Main areas of intervention to improve infant and young child feeding

- Mothers, other caregivers and families should have access to accurate, objective and consistent information about optimal feeding practices. They need to know about the recommended periods for exclusive and continued breastfeeding, the timing of introduction of complementary foods, what types of food to give to the child in what amounts and frequencies, and how to feed the child.
- Mothers, other caregivers and families should have access to skilled support to initiate and sustain optimal feeding practices and to prevent difficulties, and to overcome them when they occur. Knowledgeable health workers are well placed to provide this support, which should be delivered as part of prenatal, delivery and postnatal care, as well during services or care for the well baby and the sick child. This support entails not only effective one-to-one counselling on breastfeeding and complementary feeding, but also support from the health care system to enable mothers to initiate and sustain optimum feeding practices.
- Mothers, other caregivers, and families should be protected from misinformation and inappropriate commercial influence. Information that does not concur with optimal feeding recommendations should not be permitted in the media, and should certainly not be available through the health care system or any other public facility in accordance with the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.
- Mothers and families should be enabled to adequately breastfeed and care for their young infants, including when they have returned to paid employment. This can be accomplished through adoption and implementation of maternity protection legislation and other measures in accordance with ILO Convention 183. Adequate maternity leave, convenient day-care facilities and paid breastfeeding breaks should be available for all women gainfully employed outside the home.

7. Operational targets

The main intervention areas are already substantially covered by the *Innocenti Declaration*,² which sets four operational targets for this purpose. These targets are hereby reaffirmed in the present strategy.

7.1. The Innocenti Declaration targets

All governments should:

- appoint a national breastfeeding coordinator with appropriate authority, and establish a multisectoral national breastfeeding committee composed of representatives from relevant government departments, nongovernmental organizations, and health professional associations;
- ensure that every facility providing maternity services fully practises all ten of the *Ten Steps to Successful Breastfeeding* set out in the joint WHO/UNICEF statement on breastfeeding and the role of maternity services³;
- take action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety; and
- enact imaginative legislation protecting the breastfeeding rights of working women and establish means for its enforcement.

7.2. Many governments have taken steps towards realizing these four operational targets, and much has been achieved, notably:

- WHO and UNICEF launched the Baby-Friendly Hospital Initiative* (BFHI) in 1991 to implement the *Ten Steps to Successful Breastfeeding* and foster a health-care environment where breastfeeding is the norm. The *Ten Steps* have been defined in detail according to global criteria. By January 2001, more than 16 000 hospitals in 132 countries had been designated “baby-friendly”.
- Policies for the protection of breastfeeding have been adopted in a number of countries, including legislation and other measures concerning the marketing and distribution of breast-milk substitutes, and inappropriate marketing practices have decreased.
- Public awareness of the importance of breastfeeding has increased.

² The *Innocenti Declaration* was produced and adopted by participants at a WHO/UNICEF meeting held in Florence, Italy in August 1990, including policy makers from 31 governments and 8 UN Agencies.

³ *Protecting, promoting and supporting breastfeeding: the special role of maternity service*. A joint WHO/UNICEF statement. Geneva, World Health Organization, 1989.

- There is mounting evidence in some countries that rates for both breastfeeding prevalence and duration have increased due to actions taken to achieve these targets.

7.2.1. Achievements are not uniform, however. In some countries, protection and promotion of breastfeeding is well established, and the need is for accelerated action including providing mothers with adequate counselling and support. In contrast, in other countries, awareness- raising and legislation are only just beginning to be developed.

7.2.2. Finally, the *Innocenti Declaration* and its operational targets did not address the need for improving complementary feeding, which is one of the main components of the global strategy for infant and young child feeding.

7.3. Additional operational targets

7.3.1. This present strategy includes five additional operational targets, devised to achieve further progress. They do not supersede the *Innocenti* targets, which require accelerated and expanded action for their full implementation. Efforts should not diminish because additional targets have been set. Realization of the additional targets requires using the earlier targets as a basis, and strengthening and building on them.

7.3.2. Governments should adopt the following additional operational targets setting a date and defining measurable indicators:

- develop a comprehensive policy on infant and young child feeding;
- ensure that society as a whole, the health care system and all other sectors protect, promote and support exclusive breastfeeding for six months, and that women have access to the community support and health services they require;
- ensure timely, adequate and safe complementary feeding. Breastfeeding should continue for up to two years of age or beyond
- develop guidelines on appropriate feeding of infants and young children and on the support required by their mothers and caregivers in exceptionally difficult circumstances;
- adopt national legislation and other suitable measures for implementing the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety.

8. Components of a comprehensive policy

8.1. A comprehensive policy and related plan of action should indicate how to achieve all of the above targets, and how to create environments that protect, promote and support sound infant and young child feeding practices. This calls for:

- creation of an effective coordinating body to address the multiple aspects of infant and young child feeding;
- establishment of systems for regular monitoring of infant and young child feeding practices in order to assess trends and evaluate interventions.

8.2. A policy also requires a commitment to the following points.

8.2.1. For protection of breastfeeding:

- to adopt, and monitor application of, a policy of maternity entitlements to facilitate breastfeeding by women in paid employment, including those in atypical forms of dependent work*, such as part-time, domestic and intermittent employment;
- to implement and monitor existing national measures to give effect to the International Code of Marketing of Breast-milk Substitutes and to strengthen them when needed.

8.2.2. For promotion of optimal infant and young child feeding:

- to ensure that all who engage in communicating with the general public, including the media and educational authorities, are accurately informed, and have access to up-to-date information about optimal infant and young child feeding practices, taking into account prevailing social, cultural and environmental circumstances;
- to encourage widespread communication of this information to create greater awareness among health professionals and the general public;
- to ensure that mothers and other family members receive objective and consistent information – before, during and after pregnancy – about child health and nutrition and the advantages of breastfeeding, free from adverse commercial influences and misinformation.

8.2.3 For support of exclusive and continued breastfeeding, and appropriate complementary feeding practices:

(a) Through the health care system:

- to strengthen the Baby-friendly Hospital Initiative by monitoring and reassessing already designated hospitals in order to sustain progress achieved and to maintain high standards and commitment among health workers;
- to increase access to antenatal care and education about breastfeeding, and to delivery practices which support breastfeeding;
- to provide skilled help for infant and young child feeding throughout the health care system, including well-baby clinics, immunization sessions, in-patient and

out-patient services for sick children, nutrition services, and reproductive health and maternity services;

- to specify critical moments of contact between a child and a qualified health-care provider, and additional contacts linked to existing services;
- to promote good nutrition for pregnant and lactating women so as to improve the health of mothers and children;
- to monitor the growth of infants and young children as part of nutrition interventions, especially infants with low birth weight, those who are sick, and those born to HIV-positive mothers, and to ensure that families receive appropriate counselling;
- to provide guidelines for appropriate complementary feeding, with emphasis on locally available foods;
- to ensure adequate intake of essential nutrients through access to micronutrient supplements or, when required, local fortified staple foods;
- to enable mothers to remain in hospital with their sick children to ensure continued breastfeeding and adequate complementary feeding and, where feasible, to admit breastfeeding children with their hospitalized mothers;
- to ensure effective therapeutic feeding of sick and malnourished infants and children, including by providing skilled support for breastfeeding and re-lactation when necessary.

(b) To increase health worker skills by:

- training health workers who care for mothers, children and families on:
 - the skills needed to counsel and assist them on breastfeeding, complementary feeding, HIV and infant feeding, and, when necessary, artificial feeding;
 - feeding children during illness; and
 - the obligations of health workers under the International Code of Marketing of Breast-milk Substitutes and national measures to give effect to it;
- revising and reforming pre-service curricula for all health workers, nutritionists and related professions to provide objective and consistent information, and practical skills related to infant and young child feeding.

(c) In the community:

- to extend the principles of the Baby-friendly Hospital Initiative to home deliveries;
- to support the development of trained community counsellors for breastfeeding and complementary feeding, for example health workers, nutritionists and lactation consultants; to recognize and, where possible, to remunerate them; and to encourage referral between them and the health care system;
- to strengthen existing, and support the development of new, mother-support groups in the community, and to reinforce their links with the health care system.

8.2.4. For feeding infants and young children in exceptionally difficult circumstances:

- to ensure that health workers with knowledge and skills in all aspects of breastfeeding and replacement feeding are available to counsel HIV-infected women;
- to strengthen the Baby-friendly Hospital Initiative and other forms of breastfeeding support to prevent spillover of artificial feeding to mothers for whom breastfeeding would be the safest option;
- to include training in emergency preparedness activities dealing with optimal infant and young child feeding;
- to ensure that infants and young children in other exceptionally difficult circumstances are identified so that they can be optimally fed and their caregivers supported;
- to ensure that for any situation where breast-milk substitutes are required for medical or social reasons, such as for orphans or in the case of HIV-positive mothers, these substitutes are provided for as long as needed.

9. Obligations* and responsibilities for achieving operational targets

9.1. Governments, international organizations and civil society* are responsible for ensuring the fulfilment of the right of children to the highest attainable standard of health and the right of women to full and unbiased information, adequate health care, and adequate nutrition. They should identify their responsibilities for improving infant and young child feeding, and for mobilizing resources to fulfil them.

9.2. Governments

9.2.1. The primary obligation of governments in this context is to develop and adopt a comprehensive national policy on infant and young child feeding. This will require the commitment and efforts of a fully functioning national coordinating body. An important role of this body will be to ensure multisectoral collaboration, and to coordinate the work of government, international organizations, and appropriate

groups in civil society such as professional associations and nongovernmental organizations, so that all concerned can work together effectively.

- 9.2.2.** A national policy needs to include identification of critical moments of contact between a newborn and a qualified health-care provider – within a few hours of delivery, during the first week, and at regular intervals thereafter when feeding patterns may change and problems arise – to ensure that breastfeeding has been well established. Additional contacts can be linked to existing services, such as for postnatal care, well-baby clinics, immunization sessions, and family planning or sick-child visits.
- 9.2.3.** A detailed action plan should follow, together with allocation of responsibilities and a time frame for the plan's implementation. For this purpose, governments should seek, when appropriate, the cooperation of international organizations and other agencies. The plan should build on and be integrated with other strategies that contribute to optimal infant and young child feeding, such as the Integrated Management of Childhood Illness (IMCI) and essential newborn care. The implementation of the plan should not be delayed pending the formal adoption of a new policy, which can be a lengthy process.
- 9.2.4.** Governments are also responsible for identifying and allocating adequate financial, organizational and human resources for the support of activities at all levels. Mobilization of resources is difficult, and will require increased political will.
- 9.2.5.** In addition to national governments, regional and local governments have obligations and responsibilities; their roles will vary from place to place. Varying levels of government are responsible for hospitals and schools, training institutions and professional bodies. Some have a greater degree of autonomy than others, but they may still be considered government-regulated institutions. Specific policies and guidelines may be needed for all of these categories.
- 9.2.6.** Governments at all levels should engage in constructive dialogue with appropriate civil society organizations working for the protection, promotion and support of optimal infant and young child feeding, for example breastfeeding-support organizations, and assist in identifying resources in support of their activities.

9.3. International organizations

- 9.3.1.** The first responsibility of international organizations is to place infant and young child feeding high on the international public health agenda, recognizing it as an essential component of the rights of children and women; to strongly advocate increased human, financial and organizational resources in support of implementing this strategy; and, to the extent possible, to provide resources for this purpose.
- 9.3.2.** The specific roles of international organizations to protect, promote and support optimal infant feeding, and to support governments in their efforts, should include:

(a) In their normative role:

- development of evidence-based guidelines for action applicable to the Innocenti and additional operational targets;
- support for need epidemiological and operational research;
- promotion of the consistent use of common global indicators to monitor and evaluate child feeding trends;
- development of new indicators where needed, particularly for adequate complementary feeding; and
- improvement of the quality and availability of data.

(b) For protection: advocacy and support for development of policies:

- advocating, with governments, implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions and providing technical support in this connection; and monitoring its implementation;
- advocating ratification of ILO Maternity Protection Convention 183 and application of Recommendation 191 (2000), including for women in atypical forms of dependent work.

(c) For promotion:

- support for social mobilization activities, including use of mass media to promote optimal infant feeding in all countries, together with orientation and education of media staff.

(d) For support, guidance and capacity-building to:

- plan and monitor national programmes in the health care system and community, including the Baby-friendly Hospital Initiative;
- sensitize and train health service administrators and policy-makers;
- increase health-worker skills for supporting improved infant and young child feeding practices;
- revise pre-service curricula for doctors, nurses, midwives, nutritionists, dieticians, auxiliary health workers and other relevant groups.

9.3.3. International organizations also have specific responsibilities concerning their response to emergency situations and for emergency preparedness operations, in which there may be a need for guidance and training to help ensure that:

- aid workers are provided with accurate and up-to-date information about infant and young child feeding policies, and that they have the training and basic skills to support exclusive and continued breastfeeding, adequate complementary

feeding, and re-lactation;

- conditions are created to facilitate exclusive breastfeeding including appropriate maternity care, extra rations and drinking-water for pregnant and lactating mothers; and staff available who have breastfeeding counselling skills;
- they have clear criteria for identifying infants who may need to be fed breast-milk substitutes, whether temporarily or for the longer term, and recommend and facilitate cup-feeding* rather than bottle-feeding*;
- there is appropriate control, targeting and use of supplies of breast-milk substitutes, when these are necessary;
- the International Code of Marketing of Breast-milk Substitutes is universally implemented in its entirety, including with respect to displaced populations;
- infant and young child feeding patterns are monitored, and that corrective measures are taken, as needed, to avert spillover of artificial feeding to children who do not need it;
- appropriate and locally available food for complementary feeding are selected and used;
- families and communities, including the youngest mothers and caregivers, are involved in planning programmes and in the care and feeding of infants and young children.

9.4. Civil society

9.4.1. A new aspect of this strategy is the identification of responsibilities within civil society. There are a number of groups that have important roles in advocating women's and children's rights; and in creating an environment that supports exclusive and continued breastfeeding, and timely and adequate complementary feeding. These groups can work together with governments and international organizations to remove cultural, societal and practical barriers to appropriate feeding practices.

9.4.2. Civil society groups which have responsibilities, in accordance with government policy, where it exists, and independently, include:

- *the media*, which have an important role to play in providing information and influencing public attitudes and society's image of parenthood and child care including through their policies on advertising for products within the scope of the International Code. They should ensure that information communicated on infant and young child feeding is accurate, up to date, objective and consistent;
- *education authorities*, which can also influence attitudes among children and adolescents about infant and young child feeding practices. Accurate information should be provided through schools and other educational channels to help

prevent negative beliefs and incorrect information;

- *employers*, who should ensure that the maternity entitlements of all women in paid employment are met, including breastfeeding breaks or other workplace arrangements to facilitate breastfeeding after the period of paid maternity leave;
- *child-care facilities*, which are necessary to enable mothers to care for their infants and young children while at work, should operate in a ways that support breastfeeding.

9.4.3. Civil society groups with specific responsibility for infant and young child feeding include:

- health professional bodies,
- commercial enterprises,
- nongovernmental organizations,
- community-based support groups.

9.4.4. Health professional bodies include training institutions and universities, public and private health care practitioners and facilities, and professional associations. Their responsibilities include:

- providing technical guidance to the national coordinating body or committee;
- ensuring that professional education and training, including continuing education, of all health workers include theoretical and practical aspects of exclusive and continued breastfeeding, complementary feeding, infant and young child feeding in exceptionally difficult circumstances (including HIV), artificial feeding when necessary, and the International Code and national laws and other measures to give effect to it;
- advocating for maternity facilities to work towards the designation and maintenance of baby-friendly status by implementing the *Ten Steps to Successful Breastfeeding* and by not accepting free or low-cost supplies of breast-milk substitutes, feeding bottles or teats;
- advocating for all neonatal, paediatric, reproductive, and community health services, general practitioners and nutritionists to provide skilled support for exclusive and continued breastfeeding, and adequate complementary feeding, and to remove obstacles;
- working for the development and recognition of community support groups through training and mutual assistance, and by referring mothers to them;
- implementing, in full, the International Code and relevant national measures within facilities or associations, and ensuring compliance by all staff and suppliers;

- avoiding sponsorship, by manufacturers of products within the scope of the International Code, for activities of professional associations, educational institutions, and health worker training, and ensuring transparency in such matters as a matter of professional ethics;
- acting as advocates for, and monitors of, adequate funding for relevant promotional activities;
- providing accurate and complete information to the general public through the mass media, and monitoring the messages communicated.

9.4.5. *Commercial enterprises* include manufacturers and their associations, distributors and retail outlets. The universal responsibility of manufacturers and distributors of breast-milk substitutes, feeding bottles and teats, and any foods marketed or otherwise represented to be suitable as substitutes for breast milk, are defined in the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions.

9.4.6. Commercial enterprises have an important and constructive role to play in relation to appropriate infant feeding practices. Their first responsibility in all settings is to comply with the International Code, and with any additional national measures intended to give effect to it, whether or not legally binding. Additional responsibilities and roles for any commercial enterprise would be appropriate only after its systematic and universal compliance with these provisions has been independently verified.

9.4.7. A further responsibility of all commercial enterprises is to ensure that their employees at every level benefit in full from national maternity entitlements, with additional measures taken by employers to facilitate exclusive and continued breastfeeding.

9.4.8. Where industrial and commercial enterprises are responsible for facilities to which the public has access, for example restaurants, shops or parks, they should ensure that these facilities are supportive of breastfeeding.

9.4.9. Trade unions should also work for better conditions for employed women, including negotiating for adequate maternity entitlements, as well as for security of employment of women of reproductive age.

9.4.10. *Nongovernmental organizations* (NGOs) may work at international, national and community levels, and include religious and charitable organizations, citizens' associations and consumer groups. NGOs involved in health care include child development organizations, family clubs, childcare cooperatives, and youth associations. Their mandates and responsibilities are diverse, but many are concerned with promoting good nutrition for families and young children.

9.4.11. NGOs have a responsibility, where opportunities arise in their work, to:

- collaborate with other organizations and government, and to support the national infant and young child feeding coordinating body;

- ensure that their members have accurate and up-to-date information about all aspects of infant feeding, and that they work to replace misinformation with correct knowledge;
- ensure that exclusive and continued breastfeeding, with timely and adequate complementary feeding, are essential elements of community nutrition and growth- monitoring programmes, and that they are integrated into programmes for women, and for early child care and development;
- support the appropriate feeding of infants of mothers who have tested HIV-positive;
- empower community breastfeeding counsellors, including lactation consultants, and those who counsel families about complementary feeding, HIV and infant feeding, and infant feeding in emergencies through appropriate recognition and training;
- contribute to development of practical recommendations to enable employed mothers to continue breastfeeding, and to help them to learn the necessary skills;
- monitor compliance with the International Code of Marketing of Breast-milk Substitutes, including in health facilities, commercial premises, media, HIV-related services, and emergency settings; and inform the national coordinating body about their observations;
- avoid sponsorship from sources with a commercial interest in products within the scope of the International Code.

9.4.12. *Community-based support groups.* Parents and other caregivers are the most directly responsible for feeding their children. Parents generally are keen to ensure that they have accurate information allowing them to make the most appropriate decisions for their children; but they are dependent on the environment in which they live. They may have contact with the health care system only a few times during a child's first two years of life. The decisions that caregivers make, and the information and support that they receive in this connection, are often influenced more by community attitudes than by the health care system.

9.4.13. There are many sources of support in the community, including breastfeeding support networks, which may or may not be formally registered as NGOs. Experience demonstrates that community-based support, including from breastfeeding counsellors, lactation consultants and other mothers, whether individually or in groups, is an effective means of empowering women to feed their children optimally. There are self-help traditions in most communities onto which such support can be built.

9.4.14. Communities may help families to feed their infants optimally in a variety of ways including by:

- assessing and improving care for women, for example by reducing their workloads; and improving their social, nutritional and health status, control of resources, involvement in decisions affecting the family, and protection from violence;
- educating breastfeeding mothers and their families to ensure that mothers obtain adequate nutrition for themselves;
- involving parents and other caregivers, teachers and religious groups in planning and implementing community-based activities that support optimal infant feeding practices;
- involving men – particularly fathers – in activities that are supportive of appropriate feeding practices;
- working closely with health professionals to provide accurate information about infant feeding, and to replace misinformation;
- participating in providing community-based support for optimal infant feeding practices on behalf of, for example, employed mothers, mothers who are sick and families living with HIV.

9.4.15. Community breastfeeding counsellors and lactation consultants require knowledge and skills to support exclusive and continued breastfeeding and appropriate complementary feeding practices. They need a two-way link with the health care system for information sharing and referral. They should be recognized and rewarded for their skilled work and time commitment.

10. Conclusion

10.1. Protecting, promoting and supporting appropriate infant and young child feeding practices is an important objective of the World Declaration and Plan of Action for Nutrition, which was among the main outcomes of the International Conference on Nutrition⁴. The ability of the international community to implement the plan depends on whether the political will can be mustered in pursuit of this objective.

10.3. The special burden placed on all groups in society for ensuring the adequate feeding of infants and young children is a matter of both science and ethics. The early months of life are a precious, precarious moment. Adequate diet is more crucial in infancy than at any other time of life because of the infant's high nutritional requirements in relation to body weight and the influence of proper or faulty nutrition and care during the first months on future health and development. If the nutritional well-being of people is a pre-condition for the development of societies, it is all the more so where their most vulnerable members – infants and young children – are concerned. Governments will be unsuccessful in their efforts to accelerate economic development

⁴ *World Declaration and Plan of Action for Nutrition*. FAO/WHO, International Conference on Nutrition, Rome, December 1992.

in any significant long-term sense until optimal child growth and development are ensured for the majority.

- 10.4.** There is much encouraging evidence from around the world that governments are taking seriously their commitments to protect and promote the health and nutritional well-being of infants, young children, and pregnant and lactating women. As impressive as the progress achieved thus far clearly is, much more is required if present and future challenges are to be met. This global strategy for infant and young child feeding offers governments and society's other main actors a valuable opportunity to re-dedicate themselves collectively to protecting, promoting and supporting safe and adequate feeding of infants and young children everywhere.

Glossary of terms

Adequate complementary feeding: means *that the foods provided in addition to continued breastfeeding are rich in energy, protein and micronutrients, and given in amounts sufficient to meet a growing child's nutritional needs. Adequate complementary foods can usually be prepared from family foods which are locally available.*

Adolescent mother: means *a woman having or bearing a child between the ages 10 and 19 years). The provisions of the Convention on the Rights of the Child apply to this age group, regardless of marital or reproductive status.*

Artificial feeding: means *feeding an infant on a breast milk substitute. An infant who is partially breastfed and who is in addition being given supplements of breast milk substitutes is also artificially fed.*

Atypical forms of dependent work: means *work such as domestic, part-time and intermittent employment, according to ILO Maternity Protection Convention 183.*

Baby-friendly Hospital Initiative (BFHI): means *a programme to transform maternity practices as recommended in the Innocenti Declaration of 1990. The BFHI was launched in 1991 by UNICEF and WHO. Baby-friendly Hospitals are required to practise all the Ten Steps to Successful Breastfeeding and to implement the International Code, including accepting no free supplies of breast milk substitutes, feeding bottles, teats and pacifiers. To acquire the Baby-friendly designation, a hospital must be formally and externally assessed according to an agreed procedure using global criteria. The term Baby-friendly should not be applied to any activity or facility that has not been so assessed.*

Bottle feeding: means *feeding an infant from a bottle, whatever is in the bottle, including expressed breast milk. Bottle feeding does not mean the same thing as feeding with infant formula or other breast milk substitutes, as these may be given by various techniques.*

Breastfeeding counsellor: means *a health or community worker who has been trained to use basic clinical and counselling skills including confidence building to assist a mother to breastfeed and to overcome difficulties, and who takes the time to do so. When these helpers are chosen from among young mothers, they are often called peer counsellors. Community breastfeeding counsellors, often trained by mother-to-mother support networks, can provide easily accessible and acceptable services. Breastfeeding counsellors may also choose to become skilled in counselling for complementary feeding and HIV and infant feeding counselling.*

Breast-milk substitute: means *any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.*

Cessation of breastfeeding: means *stopping breastfeeding altogether. This may occur in the first week, or at any time during the recommended breastfeeding period . The ambiguous term weaning for the end of breastfeeding is now avoided in international usage.*

Civil society: has been defined by UNDP as *individuals and groups, organized and unorganized, who interact in the social, political and economic domains and who are*

regulated by formal and informal rules and laws. It offers a dynamic, multi-layered wealth of perspectives and values, seeking expression in the public sphere.

Civil society includes professional bodies, training institutions, industrial and commercial concerns and their associations, and non-governmental organizations whether or not officially registered as NGOs; religious and charitable organizations and citizen's associations such as community-based breastfeeding support networks and consumer groups.

Commercial infant foods: *means all industrially processed foods marketed or otherwise represented as suitable for children under the age of 12 months.*

Complementary feeding: *means the process of giving an infant complementary foods in addition to breastfeeding or to infant formula, when either becomes insufficient to satisfy the nutritional requirements in the infant.*

Complementary food: *means any food, whether manufactured or locally prepared, suitable as a complement to breast milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant. Such food has been variously referred to as weaning food, semi-solids, or solids. These less well defined terms are now avoided in international usage.*

Continued breastfeeding: *means breastfeeding after complementary foods have been introduced. Ideally breastfeeding is continued to the age of two years or beyond. When used as an indicator, measurements are made in children 12-15 months and 20-23 months of age.*

Counselling: *means a way of working with people so that they are listened to, their feelings are understood, they can discuss their situation and receive the information they need, and they make their own decisions about what will be best for them. Because counselling is not advising or telling mothers what they must do, it can help them to develop self-confidence.*

Cup feeding: *means feeding an infant or young child from an open cup, whatever is in the cup. From birth, suitable breast milk substitutes can be given to non breastfed infants by cup, including those who are low birth weight.*

Early cessation of breastfeeding: *means stopping breastfeeding sooner than is usual, to reduce the risk of HIV transmission by this route. Exclusive breastfeeding followed by early cessation sometime between 3-6 months of age, is one of the options discussed with HIV positive mothers.*

Exclusive breastfeeding: *means the infant receives only breast milk (from his/her mother or a wet nurse, or expressed breast milk) and no other liquids or complementary foods with the exception of undiluted drops or syrups consisting of vitamin and mineral supplements or medicines. Water is not permitted.*

Expressed breast milk: *means milk which has been taken out of the breasts by manual pressure or pumping.*

HIV: *means Human immuno-deficiency virus, the cause of AIDS (acquired immune deficiency syndrome)*

Home-prepared formula: means *a breast milk substitute made at household level by modifying fresh or processed full cream cow's milk or other animal milks. Addition of micro-nutrient supplements is recommended.*

International Labour Organisation (ILO) Maternity Protection Convention 183 and Recommendation 191: *adopted by the General Conference of the ILO in June 2000. The Convention states that governments should adopt and enact legislation that entitles working mothers to maternity leave of not less than 14 weeks, and make provisions for mothers to continue breastfeeding after return to their workplace, through nursing breaks or provision of child care facilities, and facilities for expression of breast milk. Once ratified by a country, the Convention is legally binding.*

Infant: means a child between birth and the age of one year (12 months).

Infant formula: means *a breast milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards to satisfy the nutritional requirements of infants up to between four and six months of age. Commercial infant formula, sold by various companies, and generic infant formula, provided by international agencies and governments, are made to the same specifications.*

International Code of Marketing of Breast-milk Substitutes, and subsequent relevant World Health Assembly Resolutions: *The Code was adopted in the form of a Resolution at the World Health Assembly (WHA) in 1981 to regulate marketing practices for breast milk substitutes, feeding bottles and teats. At a number of subsequent World Health Assemblies, additional Resolutions to clarify the Code have been adopted, and hold the same status as the Code. The Code and subsequent relevant WHA Resolutions are referred to collectively in this document for short as “the International Code”.*

The Code states that “Governments should take action, to give effect to the principles and the aim of the Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures”. This Global Strategy on Infant and Young Child Feeding recommends that countries adopt national legislation to implement the Code.

Lactation consultant: means *a health care professional or highly experienced community counsellor with specialized knowledge and skills for management and support of breastfeeding. The qualification of Board-Certified Lactation Consultants is acquired through an international professional examination.*

Maternity entitlements: means *provisions for maternity leave, job security, breastfeeding breaks, and other policies that will protect breastfeeding by employed women. (See also: ILO Maternity Protection Convention)*

Micro-nutrient supplements: means *preparations containing vitamins and minerals. Special formulations are needed for infants. One important indication for giving micro-nutrient supplements is for infants of HIV positive mothers who are replacement-fed with a home prepared infant formula.*

Mother support group: means *a community-based group of women providing support for exclusive and continued breastfeeding. A group may be informal or part of a larger network providing information, help and support from trained breastfeeding counsellors and experienced breastfeeding mothers. Groups may meet regularly or simply provide individual mother-to-mother contacts, and may be organized by health workers or lactation consultants but more frequently are managed autonomously by breastfeeding mothers within their own community.*

Obligation: *obligations have been defined in international agreements such as the Convention of the Rights of the Child and the Maternity Protection Convention. Once ratified by a country, those agreements are legally binding and governments can be held accountable for implementation of their provisions.*

Optimal infant and young child feeding: means *exclusive breastfeeding in the first six months, and continued breastfeeding with appropriate complementary feeding to the age of two years or beyond.*

Partial breastfeeding: means *that an infant or child gets breast milk and also gets any other drinks or foods. Partial breastfeeding is the commonest pattern. Breastfed children should be presumed to be partially breastfed, unless the mother states that the child receives nothing else. Between 6 and 24 months, continued partial breastfeeding with appropriate complementary feeding is recommended for all children.*

Re-lactation: means *when a woman who has stopped breastfeeding her child, recently or in the past, resumes production of breast milk for her own or an adopted infant, even without a further pregnancy.*

Replacement feeding means *the process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients the child needs for two years, until the child is fully fed on family foods. During the first six months this should be with a suitable breast milk substitute. After six months it should preferably be with a suitable breast milk substitute, and complementary foods made from appropriately prepared and nutrient-enriched family foods, given three times a day. If suitable breast milk substitutes are not available, appropriately prepared family foods should be further enriched and given five times a day.*

Spillover: means *the use of breast milk substitutes, in situations where these are made available, recommended or used for infants who need them, by other women who could safely breastfeed.*

Suitable breast milk substitute: means *home-prepared formula prepared from fresh or processed full cream milk with micro-nutrient supplements, or generic or commercial infant formula prepared according to package instructions.*

Timely complementary feeding: means *the infant receives both breast milk and complementary foods, starting when the child has completed six months of age. When used as an indicator, the measurement of timely complementary feeding is made between six and nine months of age.*

Unrestricted breastfeeding: means *that the infant or young child breastfeeds whenever and as long as she or he wishes, day and night. The infant breastfeeds at his/her own speed until satisfied, and the mother neither hurries nor ends the feed. This is also called demand feeding.*

Wet nursing: means *that someone other than the mother, usually a relative, breastfeeds the infant.*

Young child: means *children between the ages of one and two years*

Young child feeding: means *all methods of feeding children up to the age of two years, including breastfeeding, complementary feeding, artificial feeding, and replacement feeding. It also includes the transition to family foods, suitably adapted if necessary.*

Annex 2. Final list of participants

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Annex 3. Programme

28 May

1800-1900 Registration
1930 Welcome Reception and Dinner

29 May

0830-0900 Registration
0900-0930 **Opening**: Representative from the Ministry of Health, Hungary
Aileen Robertson, WHO

0930-1000 **Introduction of participants**

1000-1015 **Objectives of meeting and mode of work**
Aileen Robertson

1015-1045 *Coffee Break*

1045-1130 **A new Global Strategy on infant and young child feeding**
Randa Saadeh ; WHO

1130-1215 **Rates and trends in infant feeding practices**
Exclusive BF rates / complementary feeding practices (by area: Central & Eastern Europe; Central Asian Republics; CIS; Baltics; Southern Europe, South-East Europe; Nordic)

1215-1300 **Surveillance: Its importance as a planning and advocacy tool**
Facilitated by Francesco Branca, Italy, Jovile Vingraite, Lithuania, Dorit Kaluski, Israel & Michel Chauillac, France

1300-1400 *Lunch Break*

1400-1430 **Discussion** – possible testing of surveillance tool for European Region

1430-1445 **Introduction to group work, objectives, etc.**

1445-1600 **Group work 1**: Content (general & specific) of the Global Strategy (aim, ideas, approach, content).

1600-1630 *Coffee Break*

1630-1700 **Group work 1: continued**
1700-1800 **Group reporting and discussion**

30 May

- 0900-0930 **Overview of breastfeeding courses, peri-natal care and IMCI strategies and implementation in European Region**
Viviana Mangiaterra, Regional Adviser for Child Health, WHO
- 0930-0945 **Nutrition of pregnant and lactating women – training experiences from Central Asian Republics**
Gauchar Abouva, Kazakhstan
- 0945-1015 **Training courses in complementary feeding**
Zuzana Brazdova, Czech Republic
- 1015-1100 **Discussion on training, its development, implementation and sustainability**
- 1100-1130 *Coffee Break*
- 1130-1200 **Panel Discussion on developing strategies on infant and young child feeding for sustainability: Experiences & lessons learned**
Moderated by: Hind Khatib
Panelists: Genevieve Becker, Andrew Radford
- 1200-1230 **Discussion**
- 1230-1400 *Lunch*
- 1400-1445 **Integration of lactation management and BFHI into pre-service and in-service education:**
Fiona Dykes
- Using the UCLan BeSST tool to evaluate breastfeeding support skills**
Victoria Moran Hall
- Expanding BFHI into pediatric units**
Andrew Radford
- 1445-1530 **Integrating infant and young child feeding into national policies**
Genevieve Becker
- Integrating infant and young child feeding into the community services**
Andrew Radford
- 1530-1600 Discussion
- 1600-1630 *Coffee break*
- 1630-1730 **Group work 2:**
Sustaining interest, Government commitment to Innocenti Declaration, and new possible targets
- 1730-1800 Group reporting and discussion

31 May

- 0900-1000 **BFHI – Lessons learned and ways to safeguard quality of care**
Randa Sa'adeh and Hind Khatib
- 1000-1030 **Discussion**
- 1030-1100 **Breastfeeding and HIV/AIDS.**
Viviana Mangiaterra
- 1100-1130 Coffee break*
- 1130-1200 **Implementation of the Code, its relation to the CRC and ways to
improve Code implementation**
David Clark
- 1200-1230 **Country experiences**
Marian Gudushauri, Georgia and Daniel Polakovic, Slovakia
- 1230-1300 **Discussion**
- 1300-1430 Lunch*
- 1430-1445 **Maternity legislation**
Bodil Blaker, Norway
- 1445-1500 **Discussion**
- 1500-1530 Coffee Break*
- 1530-1700 **Group Work 3:**
This discussion will result in strategies that can be translated into Action
Plans. Discussion on how to put the global & European IYCF Strategies
into the context of the European Food & Nutrition Action Plan.

1 June

- 0900-1030 **Group work 3 (cont.):**
Finalizing plans of action: reflection of global and European strategies
- 1030-1100 Coffee Break*
- 1100-1230 **Group reporting**
- 1230-1300 **Conclusions and recommendations**

Annex 4. Group work 1–3: Feedback by sub-region

Working groups 1 and 2

Table A4.1 gives the feedback to working groups 1 and 2 by sub-region. Table A4.2 gives details of additional suggested changes to the global strategy that were brought up during working groups 1 and 2.

Working group 3

Table A4.3 gives the feedback to working group 3 by sub-region.

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Table A4.1 Working groups 1 and 2: Discussion of the global strategy

Point discussed	Baltic countries (Estonia, Latvia, Lithuania)	Central Asian Republics and Commonwealth of Independent States (Moldova, Kazakhstan, Kyrgystan)	Central and Eastern Europe (Czech Republic, Slovakia)	Hungary	Southern European and Nordic countries (France, Israel, Italy, Norway)	South East Europe (Bosnia and Herzegovina, Bulgaria, Croatia)
Section 1: Introduction						
	<ul style="list-style-type: none"> • Important to give attention to micronutrient & vitamin deficiencies and related diseases, not only to malnutrition in general • Additional difficulty can be the reluctance of medical staff to updated information; too many contraindications to breastfeeding are used without reasonable basis 		<ul style="list-style-type: none"> • A problem might be with “militant breastfeeding supporters” who sometimes lack adequate medical and lactation assistance skills and give breastfeeding support a “bad name”. • There is often a reduced availability and acceptance of breastfeeding promotion by the medical community 		<ul style="list-style-type: none"> • Add details on the link between early nutrition and late chronic disease for a better relevance to the region as a whole • Add details of the International Conference on Nutrition here 	
Section 2: Aims						
- Relevance of the overall aim	<ul style="list-style-type: none"> • Aim is relevant • Put more attention in the strategy to legislation of institutional rights and their power to the maternity health care providers. This would help insure the distribution of the guidelines (appropriate) 	<ul style="list-style-type: none"> • Aim is relevant 	<ul style="list-style-type: none"> • One of the aims of the strategy to “increase the commitment of governments...” is too general. Objectives should be measurable and accountable • There should be dated targets • The extent of changes should be monitored and analyzed 	<ul style="list-style-type: none"> • The aims are well defined and clear 		<ul style="list-style-type: none"> • The concept of the drafted strategy covers all aspects related to the accomplishment of this comprehensive policy on breastfeeding • Important to stress the capacity building of health professionals in consistence with international Recommendations • Modify Point 2.3: “There is thus an urgent need for increased political will, <i>and increased level of awareness of health care providers, public ...</i>”

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(continued) Table A4.1 Working groups 1 and 2: Discussion of the global strategy

Point discussed	Baltic countries (Estonia, Latvia, Lithuania)	Central Asian Republics and Commonwealth of Independent States (Moldova, Kazakhstan, Kyrgystan)	Central and Eastern Europe (Czech Republic, Slovakia)	Hungary	Southern European and Nordic countries (France, Israel, Italy, Norway)	South East Europe (Bosnia and Herzegovina, Bulgaria, Croatia)
Sections 3–6: Feeding guidelines						
Clarity, structure and level of details of the ideas presented	<ul style="list-style-type: none"> • Relevant 	Sufficient ideas have been included	<ul style="list-style-type: none"> • More references to scientific evidence should be included 	<ul style="list-style-type: none"> • The ideas use evidence-based information and are based on the Health 21 • Restructuring the Strategy may be needed • Some additions would be useful (see additional details below) 	<ul style="list-style-type: none"> • Ideas are sufficiently clear and well structured 	<ul style="list-style-type: none"> • We support the firm position taken (duration of exclusive breastfeeding, complementary feeding practices, supplementation • A short version to be submitted to policy makers would be appropriate. • Be more specific about the criteria concerning the introduction of foods (Section 3.3)
Usefulness of using a positive approach	<ul style="list-style-type: none"> • A positive approach is better to stress the collaboration between NGOs, civil society, and governmental institutions 	<ul style="list-style-type: none"> • A positive approach is useful 	<ul style="list-style-type: none"> • Using both positive (what to do) and negative (what not to do) examples would be useful 	<ul style="list-style-type: none"> • This approach is good 	<ul style="list-style-type: none"> • Important to think of how to overcome social barriers (e.g., maternity leave for 14 weeks) 	<ul style="list-style-type: none"> • A positive approach is better but add emphasis on implementation of already accepted responsibility of signatory countries
- Appropriateness and usefulness of the 'Rights based approach'	<ul style="list-style-type: none"> • State's policy documents should describe the procedure of family rights to obtaining full and adequate information. It is the institutional responsibility to provide this info. - who should provide and in what way? 	<ul style="list-style-type: none"> • The "Rights based approach" is suitable 	<ul style="list-style-type: none"> • The child's right to be breastfed suggests the mother's "moral obligation" to breastfeed 	<ul style="list-style-type: none"> • Some additions would be necessary 	<ul style="list-style-type: none"> • Mention obstacles to the fulfillment of rights • Stress the individual ethical responsibilities of health professionals • The rights approach should not be used with an empty meaning (e.g. HIV mother in Ethiopia) 	<ul style="list-style-type: none"> • Advocacy from respected international organisations e.g. WHO and UNICEF
- Omissions	<ul style="list-style-type: none"> • Support to mothers (and the families) who have contraindications to breastfeeding or have failed in breastfeeding (use a non-discriminative policy concerning them) 	<ul style="list-style-type: none"> • There is no omissions but some comments can be made on the content 	<ul style="list-style-type: none"> • A section on Families with drug consumption would be useful (before current section 5.8) 	<ul style="list-style-type: none"> • Add details on the importance of early child-mother bonding, and on the effects of drugs, alcohol, smoking • Stress more the importance of well-organized, accessible and continuous support and follow-up of mothers • Stress the importance of individual & group support 	<ul style="list-style-type: none"> • Add definitions for "caregiver", "optimal infant feeding", "life cycle approach" • Lactation consultants could be described as a profession or specialization • Mother's nutritional status is not an obstacle to breastfeeding 	

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(continued) Table A4.1 Working groups 1 and 2: Discussion of the global strategy

Point discussed	Baltic countries (Estonia, Latvia, Lithuania)	Central Asian Republics and Commonwealth of Independent States (Moldova, Kazakhstan, Kyrgystan)	Central and Eastern Europe (Czech Republic, Slovakia)	Hungary	Southern European and Nordic countries (France, Israel, Italy, Norway)	South East Europe (Bosnia and Herzegovina, Bulgaria, Croatia)
- Content: relevance of the re-affirmation of the <i>Innocenti Declaration</i> , level of emphasis and suggested dates for the operational targets	<ul style="list-style-type: none"> The re-affirmation of the <i>Innocenti Declaration</i> is relevant 	<ul style="list-style-type: none"> This re-affirmation is relevant The priorities included in the strategy are correct and described with suitable emphasis No dates should be used 			<ul style="list-style-type: none"> The operational targets should present a realistic schedule of achievements for the governments Important to set goals Refer to World Summit for Children goals 	
- Coherence	<ul style="list-style-type: none"> Place more attention to describing the responsibility for ensuring the rights (not just a description of the inputs) - who should ensure the rights and how? 	<ul style="list-style-type: none"> The strategy is coherent 			<ul style="list-style-type: none"> The strategy is coherent 	
- Obligations and responsibilities	<ul style="list-style-type: none"> Place more attention to describing the responsibility for ensuring the rights (not just a description of the inputs) - who should ensure the rights and how? 	<ul style="list-style-type: none"> These have been appropriately identified 			<ul style="list-style-type: none"> The obligations and responsibilities of professionals could be stressed more 	<ul style="list-style-type: none"> There is a need to stress and strengthen the role of government's institutions in charge for monitoring, analysis and follow-up (financial support is essential for the program sustainability)
- Usefulness of the strategy	<ul style="list-style-type: none"> Very useful 	<ul style="list-style-type: none"> The strategy would be useful to governments and other major players to help them move forward 	<ul style="list-style-type: none"> The strategy can be very useful, particularly if governments are sincerely interested – control mechanisms would be needed Governments should propose their own action plan and account for them some years later 	<ul style="list-style-type: none"> Mostly useful 	<ul style="list-style-type: none"> Very useful 	<ul style="list-style-type: none"> Very useful

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(continued) Table A4.1 Working groups 1 and 2: Discussion of the global strategy

Point discussed	Baltic countries (Estonia, Latvia, Lithuania)	Central Asian Republics and Commonwealth of Independent States (Moldova, Kazakhstan, Kyrgystan)	Central and Eastern Europe (Czech Republic, Slovakia)	Hungary	Southern European and Nordic countries (France, Israel, Italy, Norway)	South East Europe (Bosnia and Herzegovina, Bulgaria, Croatia)
Section 7: Operational targets						
- Strengths, weaknesses, omissions, opportunities or the additional operational targets	<ul style="list-style-type: none"> If breastfeeding and nutrition are indicators of the quality of health care service, all governments should change the standards of maternity care. Probably to state the priorities – those that implement the BFHI should be regarded as providers of better (higher quality) maternity services and should be better supported by governments 	<ul style="list-style-type: none"> Good for advocacy at government level and for the development of intersectoral collaboration But no target on maternity leave But no specific mention of families in difficult socio-economic situation 		<ul style="list-style-type: none"> Representatives from local communities should also be included in the multisectoral national breastfeeding committee (Point 7.1 bullet 1) It is important to target society as a whole, including the community and families, legislation The rights of all women should be considered: pregnant, non-working, working (Point 7.1) Ante-natal support is very important 	<ul style="list-style-type: none"> Not only should maternity services practice the 10 Steps to Successful Breastfeeding, but also paediatric units and the community (Point 7.1). Add a new additional target: "to ensure that when a woman chooses not to breastfeed her child, she must be supported by professional health workers" Also: "adopt national legislation to follow-up ILO-Convention" It might be important to add a target to "mobilize the civil society..." 	<ul style="list-style-type: none"> Strength: firm statement on duration of exclusive breastfeeding Opportunities: 1) for putting emphasis on complementary feeding; 2) for inclusion of exceptional circumstances that are not covered by other existing policies and strategies; 3) to polish existing local infant and young child feeding strategies
- Lessons to be learnt from the experience of working towards the operational targets identified in the 1990 <i>Innocenti Declaration</i>		<ul style="list-style-type: none"> Lack of information and skills in the field of public health Limited resources: human and financial 			<ul style="list-style-type: none"> BFHI principles must be included in community services and paediatrics 	<ul style="list-style-type: none"> Some targets are not achieved completely
- Target date for the implementation of the additional targets?	<ul style="list-style-type: none"> All governments should describe the implementation dates for the strategy step by step 	<ul style="list-style-type: none"> Time for implementation should be dated – 2010 	<ul style="list-style-type: none"> 2005–2010, perhaps in two steps 	<ul style="list-style-type: none"> Suggest 2010 	<ul style="list-style-type: none"> Suggest 2007 	<ul style="list-style-type: none"> Setting a deadline is important for the additional targets Suggest 2005–2010 (to vary between countries)
- Agreement with the 4 th additional target		<ul style="list-style-type: none"> This target is very important 	<ul style="list-style-type: none"> Very important 	<ul style="list-style-type: none"> Instead of using the term "exceptionally difficult circumstances", use "special circumstances" (i.e., special health, environmental, and social circumstances) 	<ul style="list-style-type: none"> Food security for all 	<ul style="list-style-type: none"> This is important
- Other groups or situations that need to be added		<ul style="list-style-type: none"> Families in difficult socio-economic situation Optimum nutrition for women during pregnancy (antenatal support) and lactation 	<ul style="list-style-type: none"> Hospitalized persons 			<ul style="list-style-type: none"> Add: optimal nutrition of women of childbearing age and during pregnancy

(continued) Table A4.1 Working groups 1 and 2: Discussion of the global strategy

Point discussed	Baltic countries (Estonia, Latvia, Lithuania)	Central Asian Republics and Commonwealth of Independent States (Moldova, Kazakhstan, Kyrgystan)	Central and Eastern Europe (Czech Republic, Slovakia)	Hungary	Southern European and Nordic countries (France, Israel, Italy, Norway)	South East Europe (Bosnia and Herzegovina, Bulgaria, Croatia)
Section 8: Components of a comprehensive policy						
	<ul style="list-style-type: none"> There is a lack of definitions of standards for monitoring system and definitions of standard, for indicators for breastfeeding and nutrition policy (clear standards for maternity services according to the aspects of breastfeeding and nutrition) (these should be governmental responsibilities) 	<ul style="list-style-type: none"> Develop uniform indicators for monitoring Capacity building needed at country level to develop monitoring evaluation system Important to include incentives for mothers to breastfeed and other appropriate feeding practices 	<ul style="list-style-type: none"> Governments should elaborate emergency nutrition plans acceptable to all health workers Include the monitoring of the expertise achieved through the education of health care professional (Point 8.2.3a) Under 8.2.3a, the point: “to promote good nutrition for pregnant and lactating women so as to improve the health of mothers and children” is too general. The governments should be responsible for achieving a certain number of consultants per 1000 live births (Point 8.2.3c) It should be specified that the use of micronut. supplements should be used in case that healthy nutrition / foods are not available for serious reasons (Point 8.2.3a bullet 8). As well, the choice of local foods should depend on the target age group. 	<ul style="list-style-type: none"> Important to describe the structure (legislation, financing system, infrastructure, training courses, staff), process and outcomes (monitoring and feedback) 	<ul style="list-style-type: none"> Suggest to try not to create new bodies if the policy can be integrated in existing bodies (Point 8.1, bullet 1) The BFHI could have different steps (e.g. give stars like hotels) Similar initiatives to the BFHI could be used at the national level (as a start) Among the civil society groups, labour unions and consumer organizations should be added 	<ul style="list-style-type: none"> The components of a comprehensive policy are fine at the global level, but would need local adjustments

(continued) Table A4.1 Working groups 1 and 2: Discussion of the global strategy

Point discussed	Baltic countries (Estonia, Latvia, Lithuania)	Central Asian Republics and Commonwealth of Independent States (Moldova, Kazakhstan, Kyrgystan)	Central and Eastern Europe (Czech Republic, Slovakia)	Hungary	Southern European and Nordic countries (France, Israel, Italy, Norway)	South East Europe (Bosnia and Herzegovina, Bulgaria, Croatia)
Section 9: Obligations and responsibilities for achieving operational targets						
	<ul style="list-style-type: none"> • There should be more collaboration between governments, civil society, non-governmental organizations, etc • Governments should not only adopt a comprehensive policy covering all the aspects of the strategy but also approve appropriate legislation for the implementation of this strategy in the national health care system and community based facilities in the most objective way 		<ul style="list-style-type: none"> • Critical moments of contact should include prenatal care (Point 9.2.2) • Point 9.2.4 is very good. But will governments agree with it? • Important to be careful when including scientific evidence into international documents: we must differentiate between hypotheses vs. proven facts. • An internat. register of high quality meta-analyses would be useful • For protection (9.3.2b), it would be important to establish a code-derived law enforcement body • The internet could be used for promotion • International standards for evaluating the extent of progress would be useful • Monitoring of skilled support provided should be monitored (9.4.4 bullet 4) 	<ul style="list-style-type: none"> • Different government levels and ministries should be involved (e.g., health, education, etc) • Among the critical moments of contact, home visits may be required (Point 9.2.2) 	<ul style="list-style-type: none"> • The World Declaration and Plan of Action for Nutrition and the International Conference on Nutrition should be mentioned earlier • The international society must also feel responsible 	<ul style="list-style-type: none"> • More specifications of the obligations and responsibilities of national governments
Section 10: Conclusions						
						<ul style="list-style-type: none"> • The conclusions are good as they refer to world declarations and plan of action for nutrition, and as child health is the basis for the development of any country
Glossary of terms						
	<ul style="list-style-type: none"> • Very useful • Place at the beginning of the document 	<ul style="list-style-type: none"> • Useful 	<ul style="list-style-type: none"> • Useful 	<ul style="list-style-type: none"> • Useful 	<ul style="list-style-type: none"> • Useful • Define "exceptionally difficult circumstances". 	<ul style="list-style-type: none"> • Useful

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Table A4.2 Additional comments to working groups 1 and 2

Point discussed	Baltic countries (Estonia, Latvia, Lithuania)	Hungary	Southern European and Nordic countries (France, Israel, Italy, Norway)	South East Europe (Bosnia and Herzegovina, Bulgaria, Croatia)
Additional comments concerning the feeding guidelines (Sections 3-6)	<ul style="list-style-type: none"> Point 3.3.1 bullet 4: details should be added. Infant 6 months of age are only starting to eat complementary foods and thus cannot eat 3 meals a day. E.g. include steps: 6-7 months 1 additional meal, 8-9 months 2 meals, 10-12 months 3 meals, 12-24 months: 5 meals per day from which 3 main meals and 2 nutritious snacks. Point 3.3.2, bullet 4: add Vitamin D. Point 3.3.2, bullet 5: important to stress that fresh and just prepared foods are more nutritionally valuable than processed foods Point 4.1.2: specify that the wet-nurse should be <i>healthy</i> Point 4.2. It would be important not to imply that home-prepared formula with micronutrient and vitamin supplements are as good as infant formula (there should be an order in the potential choices). Point 5.1. Add: without any discrimination and with appropriate support from the medical staff 	<ul style="list-style-type: none"> Point 3.3.2, bullet 4: all countries should assess what kind of micronutrient deficiencies exist in their population. Point 4.1.1, add "and if the mother does not want to breastfeed despite having receive complete information" Title of section 5. Replace "exceptionally difficult circumstances" by "difficult circumstances". Renumber 5.6 as 5.5.1 and 5.7 as 5.5.2. Section 6, bullet 3: add that both individual and mother-group counselling as support options. 	<ul style="list-style-type: none"> Point 3.3.1, bullet 3: replace "not fed by bottle" by "Bottles should be avoided". Point 3.3.2, bullet 4: add Vitamin D (Nordic countries) Point 4.1.5 says that "If milk is not available after six months, appropriately prepared family foods should be further enriched...". What is meant by this and who is expected to do this? Point 4.1.6: replace "Feeding bottles are dangerous and unnecessary" by "Feeding bottles are unnecessary and should be avoided". In countries where hygienic standards are very good, it will not be easy to say that bottles are <i>dangerous</i>. 	<ul style="list-style-type: none"> Point 3.1, remove from the last sentence: "for up to two years of age and beyond".
Additional comments concerning the operational targets (Section 7)			<ul style="list-style-type: none"> Point 7.3.2, bullet 2: put more emphasis on the government's role in promoting and supporting the strategy Point 7.3.2, bullet 3: replace beginning by: "ensure <i>policy on</i> timely and adequate ..." 	<ul style="list-style-type: none"> Point 7.3.2, bullet 3, replace by: "ensure timely, adequate and safe complementary feeding. <i>While breastfeeding lasts, and if necessary, introduce supplements in order to prevent micronutrient deficiencies.</i>"
Additional comments regarding the components of a comprehensive strategy (Section 8)			<ul style="list-style-type: none"> Point 8.2.3a, bullet 8 should be modified as follows: "to ensure that adequate intake of essential nutrients through access to <i>foods or, when required, micronutrient supplements or, local fortified staple foods</i>" 	

Table A4.3 Working group 3: Development of a comprehensive and integrated Infant and Young Child (IYC) nutrition policy

Point discussed	
Group one: Estonia, Latvia, Lithuania, Israel and Norway	
Goals	<p>Goals:</p> <ol style="list-style-type: none"> 1. to protect and promote IYC health and development by good feeding practices in sustainable ways 2. to ensure the rights of children to their health in accordance with the Convention for the Rights of Children 3. to implement Food and Nutrition Action Plan in the national health care systems in the most appropriate ways 4. to develop the facilities and guidelines at the national and regional levels 5. to involve the food industry, agriculture and environment in all aspects of the IYC nutrition policy in accordance with the Food and Nutrition Action Plan 6. to include all NGOs and civil society for collaboration on these issues
Existing political commitments that could be used to encourage governments to act	<ul style="list-style-type: none"> • Food and Nutrition Action Plan • International Code of Marketing • Convention for the Rights of Children • All WHA resolutions • All international laws related to IYC feeding, health and rights
Social inequalities and current burden to families and society caused by IYC ill-health	<ul style="list-style-type: none"> • Hygiene: food safety, water safety, culinary practices, pasteurisation, refrigeration, other methods of conservation • Micronutrient deficiencies (vitamin D, iron, iodine, zinc, calcium, etc.) as they related to growth and development • Low density foods • Overfeeding, obesity, coronary heart disease, type diabetes mellitus , IBD, celiac disease
Development of a comprehensive strategy – Actions to be taken	<ul style="list-style-type: none"> • Governments and local authorities should: <ul style="list-style-type: none"> • Approve the Action Plan (with target dates) • Prioritize the targets • Ensure public rights to information • Translate the Action Plan into laws, specially regarding the private sector • Harmonize the multidisciplinary bodies involved • Civil society should: <ul style="list-style-type: none"> • Actively participate in the implementation and monitoring of the Action Plan • Health services should: <ul style="list-style-type: none"> • Use the Action Plan in their practical everyday work • Develop their monitoring and quality insurance systems, and report to the government • Teaching institutions should: <ul style="list-style-type: none"> • Develop and incorporate the curricula in accordance with the Action Plan and review it continuously • Provide theory and practical skills • Provide continuous training for professionals • Private sector should: <ul style="list-style-type: none"> • Comply with the law and the Action Plan • Participate in monitoring mechanisms

(continued) **Table A4.3 Working group 3: Development of a comprehensive and integrated Infant and Young Child (IYC) nutrition policy**

Point discussed	
Group one: Estonia, Latvia, Lithuania, Israel and Norway	
Proposed Action Plan	<ul style="list-style-type: none"> • Strategies can be brought together using joined-up policy (food safety, nutrition, environment, health, etc.) • In order to monitor health information, a structure should be put in place to describe the process of monitoring (laws) and the outcomes to be measured (breastfeeding practices, complementary feeding practices, anthropometrical measurements, haemoglobin levels, morbidity and mortality (general public health indicators)). Monitoring should be done regularly. • Knowledge of the civil society, industry, policy makers, consumers, health care providers, should be increased. • There should be a joined-up committee, stated in the policy. This should include: members of parliament, good-will ambassadors, leaders/prominent figures, neutral figures, access to information, communication skills. • An advisory and co-ordination mechanisms should be established. It should include delegates from civil society, policy, industry and should have a national legal status. It should have the support of the government and be located under the food and nutrition policy authority.
Other considerations	<ul style="list-style-type: none"> • The support of international organisations is essential: <ul style="list-style-type: none"> • Expert advice in drafting national action plans and their implementation • Exerting international pressure on national governments to adopt and implement action plans • Regional networking would be an added value: <ul style="list-style-type: none"> • Sharing experience • Comparing success achieved in particular countries – putting pressure on local governments by referring to other countries' accomplishments
Group two: Moldova, Kazakhstan, Kyrgystan	
Goals	<p>Goals:</p> <ol style="list-style-type: none"> 1. to decrease mortality and morbidity rates 2. to improve the health and growth of infants and young children
Existing political commitments that could be used to encourage governments to act	<ul style="list-style-type: none"> • Children's Rights Convention • First Food and Nutrition Action Plan for Europe • Health 2001 • <i>Innocenti Declaration</i>, Promotion and Support of Breastfeeding • International Code of Marketing of Breast-milk Substitutes • National program for promoting the health of the population for: <ul style="list-style-type: none"> • Preventing iron deficiency anaemia and iodine deficiency disorders • Effective prenatal care • Improving nutrition of children in Moldova • Supporting breastfeeding • IMCI in some countries

(continued) **Table A4.3 Working group 3: Development of a comprehensive and integrated Infant and Young Child (IYC) nutrition policy**

Point discussed	
Group two: Moldova, Kazakhstan, Kyrgystan	
Social inequalities and current burden to families and society caused by IYC ill-health	<ul style="list-style-type: none"> • Shortage of food products (vegetables/fruits, meat/fish, iodated salt) • Insufficient capabilities to keep, preserve vegetables and fruits • Insufficient awareness at all levels: politicians and technical people, medical professionals, community • Existing old Soviet recommendations and knowledge related to feeding practices • Social inequalities (unequal distribution, social rules of women in the society, social traditions) • Lack of skills, technical methods for addressing appropriate health education • Lack of basic water sanitation and hygiene norms and practices • Pessimistic attitude of the general population due to economic difficulties • Weakness of the primary health care system
Development of a comprehensive strategy – Actions to be taken	<ul style="list-style-type: none"> • Governments and local authorities: <ul style="list-style-type: none"> • Development of a committee in the government (central and local level) with members from different backgrounds: epidemiology centres, Ministry of Health, International Organisations, NGOs, mass media, education and social centres • Development of an integrated and realistic Action Plan for the mother and child • Nomination of a national coordinator • Coordination rules for mobilising resources for the implementation of the Action Plan • Incentive for institutions and hospitals if they support the activities of the Action Plan • Civil society (including religious groups, women groups, first lady's group, etc.): <ul style="list-style-type: none"> • Sensibilisation of this group to support activities related with the Action Plan • Health services: <ul style="list-style-type: none"> • Update guidelines, normative recommendations, etc. related to the implementation of the Action Plan • Monitor all activities related to the Action Plan • Update the pre- and post-service curriculum of all relevant professionals • Strengthen existing programs such as PEPC, IMCI, and BFHI • Teaching institutions: <ul style="list-style-type: none"> • Develop special nutrition programs for teachers and school children • Include nutritional curricula into the certification of students and teachers
Proposed Action Plan	<ul style="list-style-type: none"> • In Central Asia and Moldova, only the government can integrate all intersectoral interventions. It will be an already large achievement to coordinate the different units of the Ministry of Health relevant for the implementation of the Action Plan • Standardisation and legalisation of IYC indicators (e.g., breastfeeding practices, complementary feeding, infant mortality/live birth, growth assessment, definition of anaemia, iodine deficiency disorders) • Use of suggested WHO indicators for measuring progress in the implementation of the Action Plan – PEPC, IMCI • Development of a mechanism of critical analysis and feedback of the data (and document this) • Creation of an audit system in partnership with international organisations, the civil society and NGOs. The budget should be articulated around the Action Plan. There is a lot of funds already covering some activities (e.g., IMCI, BFHI, PEPC, health education of women by UNFPA, World Bank, ABD). Other areas should be covered by governmental and local funds.

(continued) **Table A4.3 Working group 3: Development of a comprehensive and integrated Infant and Young Child (IYC) nutrition policy**

Point discussed	
Group three: Countries of Central and Eastern Europe, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary and Slovakia	
Goals	<ul style="list-style-type: none"> • <u>General objective</u>: to improve the quality of nutrition, nutritional status and health of infants and young children • <u>Short term objectives</u>: <ol style="list-style-type: none"> 1) to increase exclusive breastfeeding rates 2) to increase predominant breastfeeding rates 3) to improve timely and appropriate complementary feeding practices • <u>Long term objectives</u>: <ol style="list-style-type: none"> 1) to improve growth and development of infants and young children 2) to decrease morbidity and mortality of infants and young children in compliance with the goals ‘Health for all until 2005’ 3) to raise knowledge and awareness of the general popn especially parents towards the importance and advantages of breastfeeding
Existing political commitments that could be used to encourage governments to act	<ul style="list-style-type: none"> • WHO Resolution WHA #46.7 (September 2000) • World Summit for Children and World Food Summit • Convention on the Rights of Children • International Code of Marketing • <i>Innocenti Declaration</i> • National documents
Social inequalities and current burden to families and society caused by IYC ill-health	<ul style="list-style-type: none"> • Food borne diseases • ARI (including otitis media) • Anaemia (diluted cow milk, iron + vitamins?)
Development of a comprehensive strategy – Actions to be taken	<ol style="list-style-type: none"> 1. Accept and enforce/implement the International Code of Marketing (Responsibility of the Ministry of Health) 2. Accept BFHI as a sustainable national policy – supported by governments (Responsibility of Ministry of Health and National Breastfeeding Committee) 3. Ensure continuous education of health care providers (paediatricians, gynaecologists, nurses, midwives, patronage nurses, etc.) (Responsibility of the Ministry of Health and Ministry of Education) 4. Establish of a network of trained educators/trainers (seminars, workshops) (Responsibility of the health sector, National Committee on Breastfeeding, Public Health Committee) 5. Organize seminars and workshops for mothers and members of families 6. Organize mass media campaign 7. Include breastfeeding and complementary feeding in elementary schools, high schools, college curricula 8. Support governmental structures (national insurance agencies, health measures financed through insurance programs, benefits to low income families) 9. Increase and support sustainable activities of mother to mother support groups 10. Ensure support of NGOs (IBFAN, religious groups, women’s organizations, consumer protection organisations, etc.) and the counselling of adolescent mothers and minority groups 11. Establish a “white telephone-hotline” with continuous information and personal consultation about breastfeeding and complementary feeding practices 12. Collaborate with international organizations on compliance with international standards 13. Ensure the availability of baby -friendly facilities in the private sector (including private health care – high quality health protocols, private maternity wards)
Proposed action plan	<ul style="list-style-type: none"> • Through the National Plans for Nutrition (food and nutrition policies) <ul style="list-style-type: none"> • Regular monitoring through national health statistics systems in place (examples of basic indicators: exclusive breastfeeding, predominant breastfeeding, complementary feeding practices, supplementation, haemoglobin at 6/12 months)

Annex 5. Questionnaire on practices, policies and programmes on infant and young child feeding

This annex describes the results from the questionnaire on practices, policies and programmes on infant and young child feeding. Information were provided by 15 country representatives (Estonia, Latvia, Lithuania, Kazakhstan, Kyrgyzstan, the Czech Republic, Hungary, Slovakia, Moldova, Norway, France, Israel, Bosnia and Herzegovina, and Bulgaria) as well as from the representative of Malta who could not attend the consultation.

Section 1: Infant and young child feeding practices

Fifteen of the sixteen respondents (94%) who provided information said that their country has a national policy to promote exclusive breastfeeding (no such policy exists in Estonia). Of these, 13 said that the duration of exclusive breastfeeding specified in the policy is six months, one said that it is four months (Bulgaria), and one said that a precise duration is not specified in the policy (France). A summary of practices regarding breastfeeding and complementary feeding were described earlier in this report. A striking observation is the current lack of information on complementary feeding practices in most countries. In spite of this, it appears that various strategies to promote appropriate complementary feeding practices are already in place in almost all countries (only Kazakhstan appears not to have such strategies). This is illustrated by the results included in Table 1.

Table 1.1. Strategies to promote appropriate complementary feeding practices (n=15)

Strategies to promote appropriate complementary feeding practices	Number of countries reporting each strategy
Training courses or information to health professionals	15 (100%)
Nutrition education in health centers (well-baby clinics, immunization centers, hospitals, etc), in forms of training manuals, videos, class booklets, pamphlets, food demonstration	12 (80%)
Nutrition surveillance programme	11 (73%)
Home visits	8 (53%)
Others ^a	7 (47%)

^a Among the “other” strategies reported are the social mobilization of the population (n=1), mothers support group (n=1), antenatal courses (n=1), official guidelines for breastfeeding promotion (n=1), lectures at health professionals meetings (n=1), information on the internet for paediatricians and family practitioners (n=1).

All 15 countries that have national policy to promote exclusive breastfeeding also carry out nutrition surveillance related to breastfeeding and complementary feeding. The indicators most commonly used are breastfeeding rate (15 countries), exclusive breastfeeding rate (13 countries), and age of introduction of complementary foods (13 countries). The types of complementary foods introduced (and timing) and the prevalence of iron deficiency/anaemia were also reported (10 countries each). Other indicators mentioned by some participants included: iodine deficiency or the use of iodized salt (n=2), the intake of fruits and vegetables (n=1), anthropometric measurements (n=4), rachitism (n=2), and vitamin D/K/minerals (n=1).

Section 2: National Infant Feeding Policy and “*Innocenti Declaration*” targets

National infant feeding policy

The questionnaire included a series of questions related to the existence in their countries of a national infant feeding policy that protects, promotes and support optimal infant and young child feeding practices. Answers to these questions are detailed in Table 2.1.

Table 2.1. Existence of a national infant feeding policy (n=16)

Question	Number of countries replying “yes”
A national breastfeeding or infant feeding policy has been drafted	13 (81%)
The policy has been officially adopted/approved by the government	12 (75%)
The policy promotes infant and young child feeding practices that are consistent with international recommendations	14 (88%)
The policy covers protection, promotion, and support for breastfeeding during the antenatal, labour and delivery, and post-partum periods (including “The 10 Steps for Successful Breastfeeding”) and complementary feeding? ^a	13 (81%)
The policy routinely distributes and communicate to those managing and implementing programmes	10 (63%)
The adherence of the national policy is monitored	12 (75%)
The adherence is enforced	8 (50%)
There are appropriate breastfeeding and/or infant feeding statements integrated into other relevant national policies (family planning, integrated child health policies, etc.)	11 (69%)
There is a national policy on feeding of infants of HIV-positive mothers	6 (38%)
<ul style="list-style-type: none"> This policy is part of an overall infant feeding policy, or part of HIV policy 	6 (38%)
Infant feeding is covered in emergency preparedness provisions	5 (31%)

^a Two countries specifically mentioned that complementary feeding was not included in the policy.

In countries having a national infant feeding policy, the adherence to the policy was reported to be monitored by various entities, sometimes in partnership with organizations such as UNICEF or IBFAN. The entities most frequently mentioned include the breastfeeding coordinator and/or committee and/or equivalent committee (n=4), and the ministry of health or welfare (n=5).

Enforcement is reported to be done through governmental regulations or programmes (n=2) and health professionals (n=3). In three countries, enforcement procedures were in the process of being developed.

National breastfeeding coordinator and committee

Twelve countries reported that they had a national breastfeeding (or infant and young child feeding) coordinator and/or committee or another type of committee that had an equivalent role. The types of representatives usually included on each committee are described in Table 2.2.

Table 2.2. Representatives on a national breastfeeding/infant and young child feeding committee – or equivalent (n=16)

Representatives from:	Number of countries
Government department dealing with health	14 (88%)
Government department dealing with women's affairs	5 (31%)
Government department dealing with other issues ^a	7 (44%)
Nutrition institute or center	8 (50%)
Health professional associations	10 (63%)
Universities	10 (63%)
Medical schools	9 (56%)
Nursing schools	7 (44%)
Mother-to-mother support groups	4 (25%)
Breastfeeding counseling groups and lactation consultants	10 (63%)
Women's organizations	3 (19%)
Infant food manufacturers	1 (6%)
Bottle and teat manufacturers	1 (6%)
Advertising/marketing agencies	1 (5%)
Trade and employment groups	0 (0%)
Other NGOs	8 (50%)

^a Mentioned were: agriculture, education, health policy, health information, nursing, food safety, representative of hospitals, Institute of Obstetrics and Paediatrics

“Baby-friendly hospital initiative” achievements

The number of maternity services in the countries covered by the survey ranged from 6 to 235 (information available from 14 countries, i.e. n=14). In general, almost all (90-100%) deliveries occurred in health facilities. The proportion of facilities providing maternity services that are designated Baby-friendly (i.e., services that practice all “Ten Steps to Successful Breastfeeding”) varied from 0% (Malta and Lithuania) to 60% (Norway) with a mean of about 16% (n=14).

On average 36% of the facilities are targeted to become baby-friendly (range from 4 to 100%, information available from 12 countries, i.e. n=12) and 9% have a certificate of Commitment (range from 0 to 40%, n=14). Six respondents reported that their country had a national policy or recommendation to reassess/monitor designated Baby-Friendly Hospitals according to the “Global Criteria” (at a frequency generally ranging from every year to every 3-4 years); 5 respondents said that their country did not have such policy.

International Code of Marketing of Breast-milk Substitutes

In 81% of the countries covered in this questionnaire, the International Code of Marketing of Breast-milk Substitutes has been adopted (as law, regulation, decree, or as an EU Directive), although sometimes only partially. In 69% of the countries (11 out of 16 countries for which

data are available), national action exist to ban free and low-cost supplies of infant formula in the health care systems, while in 7 countries (out of 15 countries) national action to give effect of the Code is being monitored. In only 6 countries (out of 15 countries) was an enforcement mechanism in place. However, 13 respondents reported that national measures such as legislation, regulations, or a code of marketing, were being drafted in their country.

Legislation protecting and supporting breastfeeding among working mothers

The respondents were asked whether their country had adopted maternity legislation in accordance with the International Labour Organization (ILO) standards. Responses are described in Table 3.1.

Table 3.1. Adopted maternity legislation

Maternity legislation	Number of countries in which the legislation was adopted
Minimum 14 weeks maternity leave	15 ^a (n=16)
Paid maternity leave (at least 2/3 of previous earnings)	16 (n=16)
Entitlement to nursing breaks for 30 minutes, twice a day	12 (n=15)

^a In one country, the minimum was 12 weeks.

In eight countries (out of 15 countries for which data are available) it was reported that some groups of women were not covered by the legislations in place. These groups included for example the unemployed, self-employed women, and women working in private organizations or international enterprises.

Section 3: The national infant and young child feeding programme

Training for health care providers

Representatives from 14 countries (excluding France and Bosnia & Herzegovina) provided information on training for health care providers. In all fourteen countries training programmes on lactation management and/or breastfeeding counseling courses exist. In comparison, 86% (12 out of 14) of the countries have a training programme on appropriate complementary feeding practices.

In most countries there is a cadre of designated breastfeeding counselors working in the health care system (71% of 14 countries) and community (79% of 14 countries), while in all countries the pre-service curriculum include breastfeeding and complementary feeding. The respondents reported that 18-hour lactation management courses and/or 40-hour breastfeeding counseling courses have been introduced in their countries. However the frequency of their application varies considerably among countries (from a few to most hospitals).

Other types of training, reported to be regularly conducted, include short courses for hospital managers and various health professionals (e.g., medical assistants, nurses, family practitioners, etc.), for pregnant women (antenatal courses), and for teachers and/or schoolchildren. Large variations exist among countries.

In less than 40% of the countries (5 out of 13 with available data), a training programme for HIV and infant feeding exists.

Community outreach, including mother support

In most countries (11 out of 14, i.e., 79%) mother-support-groups are active, sometimes throughout the country, but other times only in some cities, thus reducing coverage.

Information, education and communication

All respondents who provided information on the existence of a public health education programme on infant and young child feeding in their country (n=14) said that such programme is in place. These could take various formats including mass media campaigns, breastfeeding week/day, conferences/seminars for health workers and mothers, programmes for school children, magazines, television publicity, posters, leaflets, etc.

With regards to the provisions for feeding of infants in special care baby units, three respondents said that it was cup feeding and five that it was or was usually bottle feeding (sometimes with the exception of some hospitals designated or targeted as BFH). One respondent said that it varied.

(More information on a specific mass media campaign in Central Europe is included in Annex 8 “Mass Media in the Service of Health”)

Integration of infant and young child feeding (IYCF) into other programmes

In about 77% of the countries (on a basis of 10 with available data) infant and young child feeding programmes are integrated into existing initiatives or programmes. These include, among other examples, the Integrated Management of Childhood Illness (IMCI, n=3), family planning (n=5), national health or public health programmes (n=2), education programmes (n=1), medical guidelines (n=1), health care system programmes (n=1), and growth monitoring.

Research for decision-making

Most respondents (13 out of 14) reported that research on issues related to infant and young child feeding are currently going on in their countries (some being supported by WHO and/or UNICEF – three countries). However, only four respondents said that these projects are well funded.

Annex 6. Abbreviations

BFHI:	Baby Friendly Hospital Initiative
EBF:	Exclusive breastfeeding
ILO:	International Labour Office
IMCI:	Integrated Management of Childhood Illness
IYCF:	Infant and Young Child Feeding
NGO:	Non-Governmental Organization
PEPC:	Promoting Effective Perinatal Care
UK:	United Kingdom
UN ACC:	United Nations Administrative Committee on Coordination
UNAIDS:	(Joint) United Nations Programme on HIV/AIDS
UNFPA:	United Nations Population Fund
UNHCR:	United Nations High Commissioner for Refugees
UNICEF:	United Nations Children's Fund
WHA:	World Health Assembly
WHO:	World Health Organization

Annex 7. Group work instructions: I, II and III

Working group I

General contents of strategy

1. **AIM:** Is the overall aim of the strategy relevant?
 - the improvement of infant and young child feeding
 - the concept of optimal infant and young child feeding
2. **IDEAS:** Are the ideas in the strategy new enough?
 - Are they sufficiently clear and appropriately structured and expressed?
 - Are the length and level of detail and scope of the strategy appropriate?
3. **APPROACH:** Is it useful to have a positive approach such as “What to do” useful, or should there be more description of barriers and problems?
4. **RIGHTS:** Is the “Rights Based Approach” appropriate and helpful?
 - Is the emphasis suitable?
5. **OMISSIONS:** What is missing and has not been addressed that ought to be?
6. **CONTENT:** Is re-affirmation of the Innocenti Declaration relevant?
 - Are the new operational targets the right priorities, with suitable emphasis?
 - Should they be dated targets or more general?
7. **COHERENCE:** Is it sufficiently coherent, and unified, or divided in too many unconnected points?
8. **OBLIGATIONS and RESPONSIBILITIES:** Have these been appropriately identified?
9. **USEFULNESS:** Would this Strategy be useful to governments and other major players to help them move forward?

Detailed comments

- Please discuss in more detail, the contents of individual paragraphs in the strategy paper. Each group will be given a copy of the strategy printed with double spacing, to enable them to write their specific comments in the text itself. Please return the copy with comments of the group after the working group session.

Please discuss:

1. The Challenge
2. Aim of the strategy
3. Optimal infant and young child feeding
4. Other feeding options
5. Feeding in exceptionally difficult circumstances

6. Main areas of intervention to improve infant and young child feeding
7. Usefulness of the section on “Glossary of Terms”

Working Group II

Discussion on section 7. “Operational targets”, 8, 9 and Conclusions

Proposed new additional targets – Summary

All governments by the year should have:

- adopted a comprehensive policy covering all aspects of infant and young child feeding based on the Global Strategy and “Feeding & Nutrition of Infants & Young Children” (and as endorsed by European Regional Committee resolution, September 2000);
- ensured that all services in the health care system protect, promote and support exclusive breastfeeding for six months, and that women have access both to these services and to support in the community;
- ensured that continued breastfeeding with timely and optimum complementary feeding to two years and beyond is protected, promoted and supported throughout the health care system and by civil society;
- taken action to ensure appropriate feeding of infants and young children in exceptionally difficult circumstances (emergency situations, families affected by HIV, adolescent mothers, other groups);
- adopt national legislation and other suitable measures for implementing the International Code of Marketing of Breast-milk Substitutes.

The strategy also re-emphasizes the operational targets of the 1990 Innocenti Declaration.

Questions to facilitate discussions in the group:

1. What are the strengths, weaknesses, omissions and opportunities of the additional operational targets (which are summarized above).
2. Are there lessons to be learnt from the experience of working towards the operational targets identified in the 1990 Innocenti Declaration?
3. Would you like to see a target date for the implementation of the additional targets?
4. Do you agree with the fourth target above i.e. “the exceptionally difficult circumstances”?
 - Are these necessary and appropriate?
5. Are there other groups or situations that need to be added here?
 - e.g. ensured information for women on optimum nutrition for themselves during pregnancy and lactation as part of their ante-natal support.
6. Please comment on the Components of a comprehensive policy.
7. Please discuss Obligations and responsibilities for achieving operational targets
 - national governments
 - civil society
8. Please discuss the Conclusions

Working group III

Develop a comprehensive and integrated Infant and young child⁵ (IYC) nutrition policy

Proposed outline for policies and action plans

Each group is invited to list the actions necessary to bring about desirable improvements in IYC nutritional health, including improved growth and development. What actions are required to harmonize inter-sectoral policies and to develop a more comprehensive and integrated approach to IYC nutritional health.

1. Goals – what should be the main goals of a comprehensive policy?
2. Are there any existing political commitments that could be used to encourage government to act?
3. Social Inequalities and Burden of Nutrition-Related Ill-Health – describe the current burden both to families and society caused by IYC ill health.
 - Poor hygiene practices related to trends in inappropriate feeding practices
 - Nutrient deficiency and insecurity related to trends in inappropriate feeding practices
 - Poor growth and development related to trends in inappropriate feeding practices

Outline the current situation in the European Region and potential risks and burden from nutrition-related ill health that might be expected in the future.

4. Start to develop a Comprehensive Policy (use blank table supplied if wished) which incorporates actions by:

Government/local authorities

Civil society

- Health services
- Teaching institutions (including schools, universities etc)
- Private Sector
- Others

5. Proposed Action Plan

- Develop a comprehensive approach – how can the strategies be brought together?
- Monitor Health information – what information/data should be collected on a regular basis (how often?)
- Improve knowledge – whose knowledge needs improving and why?
- Strengthen partnerships – how can partnerships be strengthened (which partners)?
- Establish an advisory and co-ordination mechanism – where would this mechanism be located. What would the budget be and where would the funds come from?

6. Additional considerations

Each group should identify what action and support from WHO (within the context of the European Food and Nutrition Action Plan), UNICEF and other International and European

⁵ Age range 0-3 years

organizations would help to develop comprehensive IYC nutrition policies. Can “added added-value” be achieved from several neighbouring countries forming a network and working together?

Annex 8. Mass media in the service of health

Mass media in the service of health

Along with the onslaught of Western music, products and movie stars, Western television is becoming a fact of life throughout Central and Eastern Europe, grabbing huge ratings with programs like quiz shows, talk shows and youth videos. Because these shows attract millions of viewers, Centre for Communications, Health and the Environment (CECHE) and its partners decided to put all of this “bad” television to “good” use.

The ambitious aim of CECHE’s mass media public education program – in place since 1992 – is to harness the style, techniques and vocabulary of mass-market electronic media in an effort to disseminate public service messages to inform Czechs, Hungarians, Russians, Poles, Asians and people around the globe about healthy living. The program is also aimed at the prevention of cardio-vascular disease, cancer and other leading killers through measures such as education on smoking cessation and a better diet. CECHE’s five part TV series *A Family Year*, is one produce of this mass-media effort.

A Family Year makes its mark. Completed in winter 1996, *A Family Year* has been broadcast to a potential audience of some 400 million over the past two years on national channels in 17 CEE-NIS countries, including all 12 NIS countries, Hungary, Poland, Romania, the Czech Republic and Slovenia. While broadcasts and reruns continue, the last 12 months have been devoted to assessing the series’ impact on audiences in Hungary, the Czech Republic, Poland and Russia.

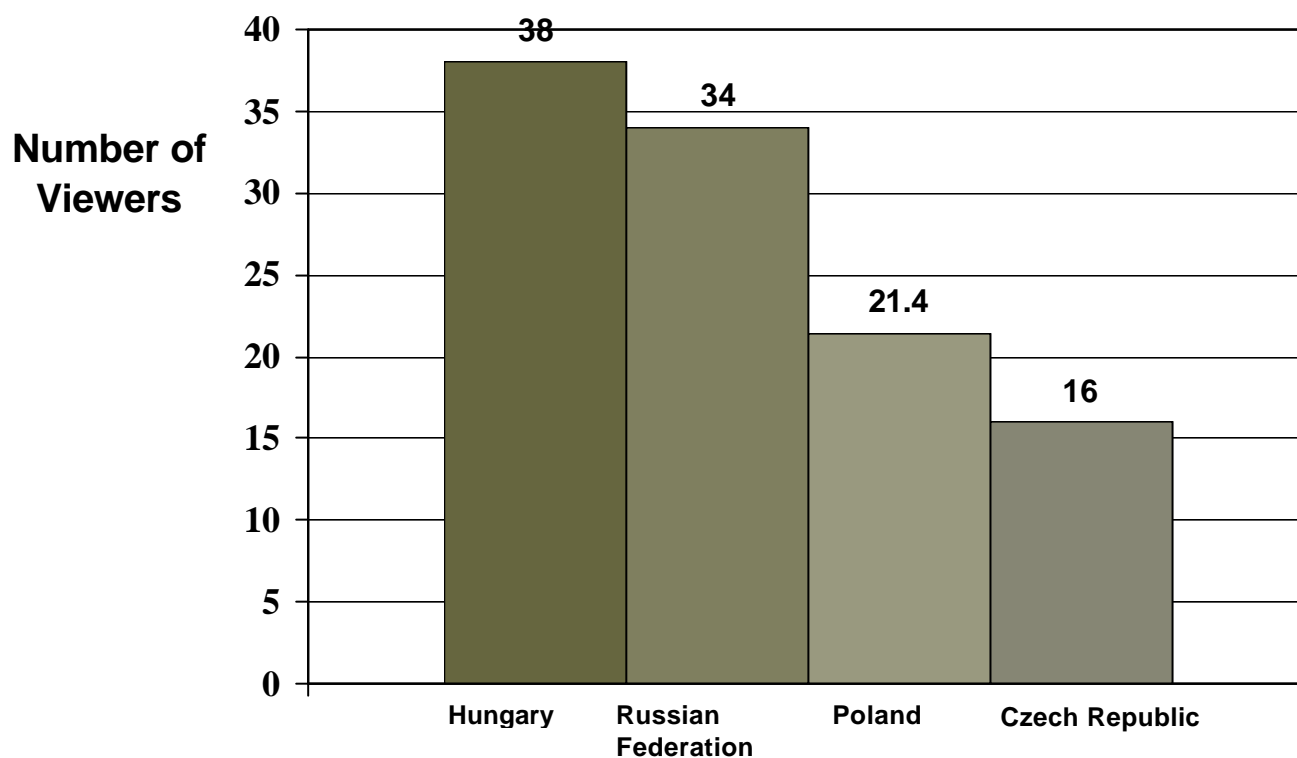
A Family Year was designed to provoke discussion, enhance understanding of health and environmental issues, encourage individuals to make lifestyle changes that reduce risks, and prod decision makers to shape better future health and environmental programs and policies. Each of the five 27 minute episodes focuses on one or two related issues (e.g. cigarette smoking and alcohol abuse, diet and the prevention of chronic illness, maternal and child health, and the health impact of environmental pollution) and features illustrative examples from one family each in Hungary, the Czech Republic, Poland and Russia.

CECHE’s multinational team of researchers evaluated the series in these four countries under the watchful eye of Syracuse University communications Specialist Dr Fiona Chew and Dr Sushma Palmer, Chairman of CECHE. Using a two-stage longitudinal field study, the team interviewed more than 1000 viewers and non-viewers immediately after the series broadcast; both groups were also interviewed three to 12 months later. In addition, the team conducted a survey of health policy-makers that sought perceptions of program intact and lessons learned about strategies for solving health problems.

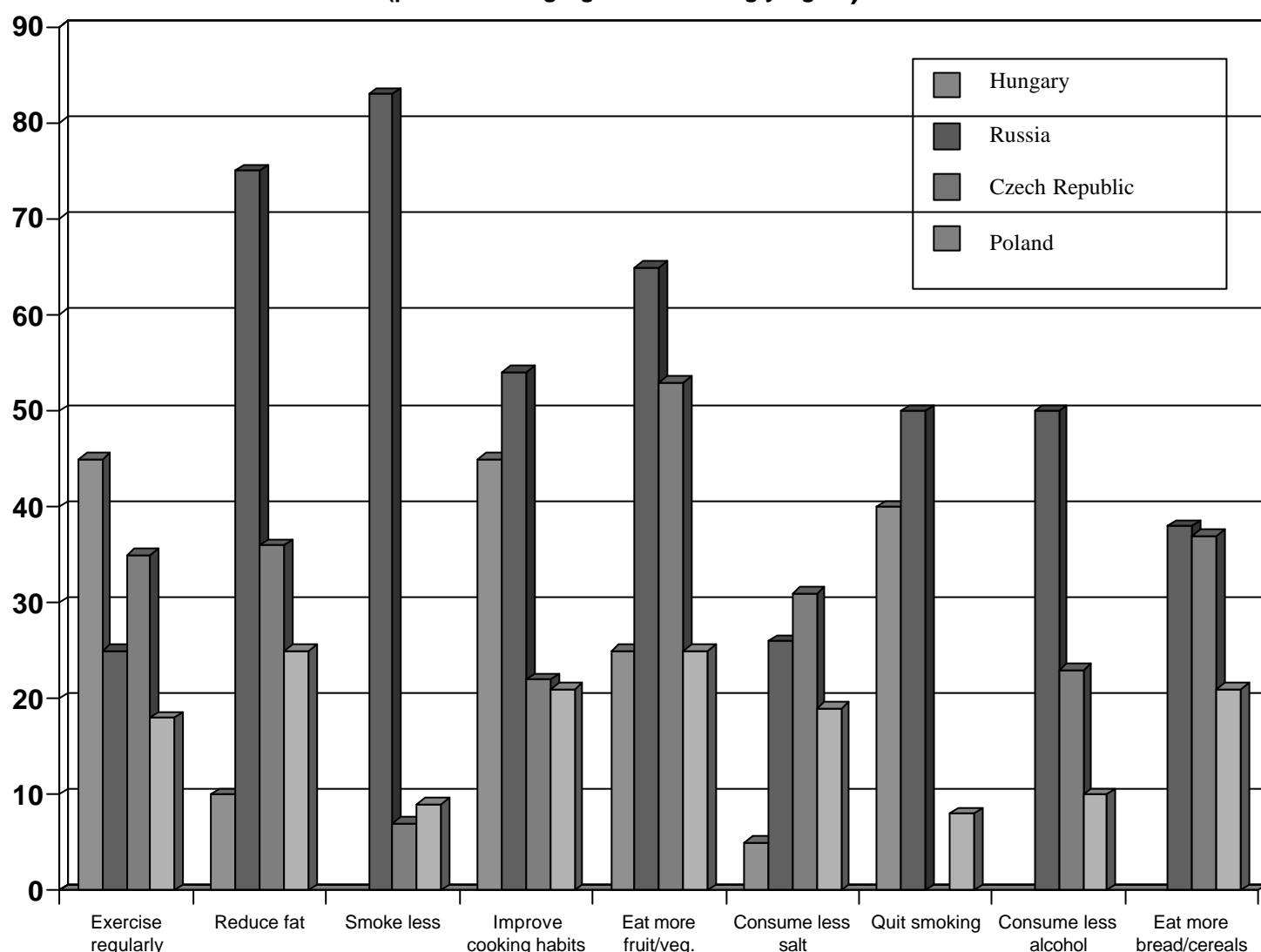
The reported lifestyle improvements among the Central Europeans surveyed far exceed the results of similar health communication efforts among American television viewers. *A Family Year*, however, measured short- and medium-term change, which are likely to show higher gains than long-term sustained change as measure in comparable American studies. The actual change sustained by viewers of *A Family Year* in Hungary, Russia the Czech Republic and Poland ranged from 5 to 53%.

A Family Year is among the first attempts to use a television series for positive health impact in the CEE-NIS region. And results indicate that integrating health programming into daily TV schedules could have a powerful impact on CEE-NIS audiences, who are less accustomed to health programming than American audiences and are thus more likely to be influenced by programs to improve their lifestyles, and, ultimately, their health.

Viewers reporting actual improvement in lifestyle 3-12 months after viewing "A Family Year"



**Viewers' Actual Improvements in Lifestyle
(percent Rating Agree and Strongly Agree)**



A Family Year appears to have made a mark on viewers in Russia and Central and Eastern Europe:

- Hungarian and Russian viewers reported major gains in health and environmental knowledge and motivation to improve lifestyle. Eighty-nine percent of Hungarian, 66.3 percent of Russian, and more than 30 percent of Czech viewers reported a desire to view more such programs.
- Assessment of actual lifestyle change showed that 38 percent of viewers from Hungary, 34 percent from Russia, 21 percent from Poland and 16 percent from the Czech Republic indicated a positive lifestyle change as a result of the series.
- A majority of Hungarian (64 percent), Russian (71.7 percent) and Polish (61 percent) viewers, and about one-third of Czech viewers reported that they learned new, very useful and practical information that they would apply to improve their lifestyles.
- An impressive proportion of viewers from each of the four countries reported improvements in their eating habits and lifestyles (30-85 percent): eating more fruits and vegetables and whole grains and breads; reducing fat and salt intake; exercising more; quitting smoking (5-85 percent); drinking less alcohol; and adopting healthier cooking habits.

Annex 9. Documentation

PROVISIONAL LIST OF WORKING PAPERS AND BACKGROUND MATERIAL

Working papers

- /1 Provisional list of working papers and background material
- /2 Scope and purpose
- /3 Provisional agenda
- /4 Provisional programme
- /5 Provisional list of participants
- /6 Working Group Paper I
- /7 Working Group Paper II
- /8 Working Group Paper III
- /9 Draft – Global Strategy for Infant and Young Child Feeding
Developed jointly by WHO and UNICEF
- /10 Questionnaire on Practices, Policies and Programmes

Background Documents

The First Action Plan for Food and Nutrition Policy, WHO European Region, 2000-2005. Nutrition and Food Security Programme, WHO Regional Office for Europe. 2001. English. Draft available in Russian.

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